



Telford & Wrekin Safeguarding Partnership

Child Safeguarding Practice Review – report

Baby Elizabeth

Independent Reviewer: Kevin Ball

1. Introduction

1.1. In November 2019, at 7 weeks old Baby Elizabeth sustained two significant head injuries whilst in the care of her mother. Her mother, who is of Congolese heritage, had only recently moved into the local area, having relocated from London. Paediatric examination noted extensive bruising and swelling to Baby Elizabeth's head and other areas of her body. In the absence of any explanation about these injuries in a non-mobile baby, they were confirmed as being consistent with a non-accidental injury. Baby Elizabeth's mother was arrested by the Police for attempted murder, and subsequently convicted of causing grievous bodily harm, with intent to do so, contrary to section 18 of the Offences against the Person Act 1861. She was convicted by unanimous verdict in November 2020 and sentenced to 14 years imprisonment. In August 2022 Baby Elizabeth sadly died whilst in the care of the local authority; it is believed as a result of the effects of the injuries suffered. The Police re-opened their investigation with a view to pursuing a homicide investigation; the mother has subsequently been charged with murder and received further sentencing.

1.2. Telford & Wrekin Safeguarding Partnership conducted a Rapid Review following the serious incident in December 2019, in accordance with statutory guidance¹. A number of immediate learning points were captured as part of that initial process, local actions for improvement agreed, and learning disseminated across the Partnership. The national Child Safeguarding Practice Review Panel² recommended a local Child Safeguarding Practice Review (CSPR) be commissioned however this was not taken forward by the Partnership at that stage; the reasons for remain unclear. Following Baby Elizabeth's death in August 2022 the Partnership revisited the learning and actions identified during the Rapid Review, resulting in a decision to initiate a local CSPR. Given the circumstances of this case, the review wished to examine what additional learning there might be about the quality and effectiveness of the local response to families that are either transient between local authority areas, or are re-housed from other authority areas, and where there are concerns about risk or vulnerability.

2. The approach to this review

2.1. The decision to commission a local CSPR was confirmed in August 2022. The following steps were then taken:

- In October 2022 the Partnership commissioned Kevin Ball, Independent Reviewer³, to undertake this CSPR.
- An initial Review Panel of local agency representatives was convened in November 2022 to assist with the smooth and timely completion of the review.
- Requests for single agency reports were sent out in December 2022, and returned in January 2023. This included an opportunity for any practitioners in post that did have contact with the mother, to contribute.
- Further Review Panels were held as needed in January, February and April 2023.

2.2. The following agencies have contributed to this review:

- Telford & Wrekin Council Children's Services/MASH/Early Help/Family Connect
- Telford & Wrekin Council Housing Solutions

¹ Working Together to Safeguard Children, 2018, HM Government.

² Working Together to Safeguard Children, 2018, HM Government.

³ Kevin Ball is an independent and experienced reviewer.

- West Mercia Police
- NHS Shropshire, Telford & Wrekin Integrated Care System
- Shrewsbury & Telford Hospital NHS Trust
- Shropshire Community Health NHS Trust
- Safeguarding in Education Service (relevant for school age children that might also be relocating)
- London Borough of Waltham Forest (housing department & children's services)
- London Borough of Haringey (housing department & children's services)
- Homerton University Hospital NHS Foundation Trust

2.3. The timeframe under review is from June 2019 when services in the London Borough of Waltham Forest first became aware of Baby Elizabeth's mother's pregnancy through to the November 2019, when Baby Elizabeth suffered the injuries.

2.4. Seeking the contributions of family members has been considered. Baby Elizabeth's mother was given the opportunity to contribute. Baby Elizabeth's father was located and offered the opportunity to contribute to the review; he did not however, take this opportunity.

3. Summary account of relevant case history

3.1. Chronological information gathered highlights the following notable information and events:

February 2019: Baby Elizabeth's mother attended her antenatal booking appointment at Homerton University Hospital, London, having booked at an appropriate gestation (10 weeks and 3 days), she attended the appointment alone, stated she was unemployed, living alone and had originated from the Congo; no details about the baby's father were given and the mother reported she was not speaking with him. The mother also reported having a difficult relationship with her own father and an aunt, so was living in a hostel. No issues regarding domestic violence were raised, stating she was happy to be pregnant. Records stated that she was supported by friends and another 'aunt'. Further antenatal appointments were attended in April and June.

April 2019: During an antenatal appointment the Midwife became concerned that the mother might have learning difficulties; mild learning disabilities were subsequently confirmed by the GP.

May 2019: Given that the mother was also living in a hostel in the Waltham Forest area, having become estranged from her own family in the Hackney Borough area, a referral was made to Waltham Forest Children's Services by the Homerton University Hospital Midwife. The mother informed Waltham Forest Housing Services that she had been residing at a YMCA since December 2018, but had been served with a notice to end her stay as she was pregnant and the accommodation was only for single people. This resulted in her being categorised as 'homeless'. The Council agreed to support her, given her pregnancy, and based on the outcome of their assessment, was considered suitable for a placement - this placement was outside of London and was based on her stating she had an 'aunt' and 'sister' in the prospective area.

June 2019: The mother accepted the offer of a housing placement in Telford, moving into the area at the end of June. The Homerton University Hospital Midwife expressed concern about this, given the anticipated isolation the mother would likely experience by being placed outside of London. This also impacted on Waltham Forest Children's Services ability to conduct their initial assessment, resulting in no full assessment being carried out. A referral was consequently made to Telford & Wrekin's Children's Services by Waltham Forest Children's Services. During a follow-up call by the Homerton University Hospital Midwife, the mother stated that she would temporarily move back to London to be with her sister until the baby was born. It is unclear whether this move back to London actually happened given the very short timescales involved.

July 2019: The mother registered with a local GP Practice in Telford. Given the presence of sickle cell a Haemoglobinopathy Nurse had visited the mother at her accommodation in Telford. The Nurse was unable to meet with the mother due to the door being locked, the mother not having a key, and not being able to open the door – but did have a brief conversation with her, being informed by the mother that she planned to return to London.

This concerned the Nurse who made contact with Homerton University Hospital Midwife, who in turn, shared this information with Telford & Wrekin Children's Services. By the time this information had been received, the mother had returned to the London area and prompted Telford & Wrekin Children's Services to share the information with the appropriate London Borough.

August 2019 onwards: Baby Elizabeth's mother moved back to the Borough of Hackney. Later in August she gave an address in the Borough of Haringey. Baby Elizabeth was born in September in London. In mid-October, notifications were received by the Health Visiting Service in Telford & Wrekin that both the mother and Baby Elizabeth had relocated back in the Telford area. In November, Baby Elizabeth's mother took the baby to the GP with concerns about swelling to her head and eyes; no safeguarding related concerns were noted, and eczema and a mild allergic reaction were diagnosed (mild periorbital oedema). Five days later, Baby Elizabeth suffered serious injuries.

3.2. Relevant background information gathered as part of the Police investigation is noted regarding the mother being the victim of modern slavery, exploitation and abuse as a child whilst living in the London area. Also, in August 2017, Baby Elizabeth's mother was reportedly homeless whilst in the London Borough of Hackney area.

4. Findings & learning

1. From review of information, key issues which arise are:

- The challenge of tracking the mother's movements across a number of local authorities.
- Recognising vulnerability of transient parents, as well as assessing risk to unborn children of transient parents.

4.1. The challenge of tracking the mother's movements across a number of local authorities.

4.1.1. In this case, Baby Elizabeth's mother was known to have moved a number of times, within a short timeframe, across multiple local authority areas from the point that the pregnancy was first registered in February 2019. She moved between Hackney, Haringey, Waltham Forest, and Telford all within a seven month period – but often with moves back and forth between these authorities during this period – especially, it seems, during the later stages of pregnancy. However, the mother appeared to gravitate back to Homerton Hospital for her maternity care with her returning there to give birth. Homerton Healthcare NHS Foundation Trust Midwifery Service showed good practice and made referrals to Hackney, Haringey, Waltham Forest and Telford Children's Services over this time-frame.

4.1.2. These transitions created challenges for all professionals involved, especially as at the time of the moves, no particular concerns had been identified that met a child protection threshold in terms of professional concern about how she was caring for herself and in turn, the unborn child. Based on records and discussions, the issues identified at this stage mainly centred on what support she might need in order to care for a new-born baby given some learning difficulties had been identified, and that her housing needs were not settled.

4.1.3. Information reviewed indicates that each London Borough – Hackney, Haringey and Waltham Forest – received information about the mother, and either appropriately shared it with other relevant authorities or attempted to begin a formal assessment process. On this basis, it does appear that information was shared appropriately, and in a timely manner. Waltham Forest were unable to complete their initial assessment due to the mother being relocated to Telford – but they did then notify Telford & Wrekin Children's Services that she had moved to the area. Combined, this made it extremely difficult for any one single authority to gain an over-view or history about the mother's background or true circumstances, her intentions, and her preparedness to become a parent. As no explicit child protection issues had been identified, the threshold for assessment and intervention remained at an early help and support level. Research⁴ published in 2016 reminds us that child protection issues do not necessarily always come neatly packaged and labelled as such '*... lack of certainty and the constant professional concern about whether the child is safe enough is at the heart of child protection and wider safeguarding practice. ... more than half of serious*

⁴ Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, Final report May 2016, p. 237, University of Warwick & University of East Anglia, HM Government. g

case reviews occur for children who are below the threshold for children's social care, [therefore] all those working with children and families need to be alert to children's need for protection in their every-day work ...'.

4.1.4. For those children that face risks to their safety and welfare, moving across local authority areas with their parents or carers can be a complicating risk factor. Research⁵ conducted into other case reviews highlights transience as a risk factor. Research⁶ has noted '*... Several serious case reviews involved families who appeared to live a very transient lifestyle, with frequent moves and little sense of attachment to any geographical location or community ...'.*

4.1.5. Policy and procedures to support professionals respond to such circumstances is available but mostly covers in detail children subject to Child Protection Plans or Child in Need Plans; lower level concerns, worries or vulnerabilities is less comprehensively covered. The London Child Protection Procedures provides a clear policy⁷ and guidance about this issue, and explicitly refers to unborn children (1.5) and pregnant women (1.6). The Regional Child Protection Procedures for West Midlands similarly provides guidance⁸ on children and families moving across local authority boundaries, as well as (although very similar) Protecting Children Who Move Across Local Authority Borders (revised January 2013). Both policy documents/pages provided by the West Midlands procedures offer very light touch reference to unborn children or pregnant women. It is therefore recommended that the West Midlands procedures are strengthened to align with the London procedures given the relative frequency such circumstances are likely to arise.

4.2. Recognising vulnerability of transient parents, and assessing risk to unborn children of transient parents.

4.2.1. The over-riding issue, as outlined above, does appear to be the lack of permanence, or being settled in one area for any meaningful period of time, which significantly hampered any one agency or local authority area conducting a thorough assessment and gaining a true understanding about the mother's circumstances and intentions.

4.2.2. There were however, some risk factors that warrant comment to highlight learning. The known factors at the time that raised concern and which justified further enquiry included:

- *Learning difficulties & disabilities* – There are varying accounts of whether the mother had learning difficulties or learning disabilities; it seems however, that it was established following the efforts of the Midwife making contact with the GP in April 2019 that mild learning disabilities were confirmed. Recording on this remains inconsistent with little differentiation between learning difficulties or learning disabilities. Understanding the difference will be important to providing the right support. Mencap⁹ define learning disability as '*... a reduced intellectual ability and difficulty with everyday activities – for example household tasks, socialising or managing money – which affects someone for their whole life ...' whereas '... There are many different types of learning difficulty, some of the more well known are dyslexia, attention deficit-hyperactivity disorder (ADHD), dyspraxia and dyscalculia. A person can have one, or a combination. As with learning disability, learning difficulties can also exist on a scale. A person might have a mild learning difficulty or a severe learning difficulty. The same is true of learning disabilities ...'.* As no one local authority area was able to begin any meaningful assessment work, and Baby Elizabeth had not yet been born at the point of the majority of professional contacts, understanding the extent and impact of mild learning difficulties or disabilities on the mother's practical parenting capacity was unknown. In the overall scheme of things, this may not have been a determining risk

⁵ a) Learning for the future: final analysis of serious case reviews, 2017 to 2019 December 2022, University of East Anglia & University of Birmingham, HM Government.

⁶ Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014, Final report May 2016, p.87, University of Warwick & University of East Anglia, HM Government.

⁷ London Child Protection Procedures: Children and Families Moving Across Local Authority Boundaries, revised October 2022. [Procedures](#)

⁸ Regional Child Protection Procedures for West Midlands, Protecting Children Who Move Across Local Authority Borders (revised 2013 - [Procedures](#)) and the policy Children and families moving across local authority boundaries (1.16 - [Procedures](#)),

⁹ [Mencap: Learning disability or learning difficulty?](#)

factor; however, given the lack of permanent and settled accommodation, potential social isolation limiting support networks, and this being the mother's first child, assessing the impact of mild learning difficulties or disabilities prior to, and post birth, becomes much more critical.

- *Being locked in her accommodation on one occasion* – In July 2019 the mother was found to be locked in her own accommodation, had no key to exit it, and was unable to allow a Haemoglobinopathy Nurse into the accommodation. This was identified as a concern by the Nurse and correctly referred to Telford & Wrekin's Children's Services, albeit via another professional that knew the mother. In isolation, this is a concerning finding for any professional to encounter. The mother's history of being a previous victim was not known about at this stage, but it is argued that it is not unreasonable to be concerned about issues such as coercion, exploitation, modern slavery and being trafficked. Triangulating information with other professionals, the mother's known history of moving between different local authority areas, being relatively young and from the Congo, having learning difficulties and placed in accommodation away from her established support networks, would be an important step to understanding the situation better. The fact that the mother was pregnant made this situation additionally, more worrying.
- *Race, ethnicity, culture and language* – Acknowledging the mother's race and ethnicity, along with any cultural implications is an important learning point. Records examined for this review have highlighted that issues relating to ethnicity and learning difficulty were either not recorded, or inconsistently recorded in a number of agency records. The mother originated from the Congo arriving in the UK as a child. It has come to light that the mother was abused, exploited and a victim of modern slavery as a child whilst in the UK. Undoubtedly, the mother would have been living with some degree of trauma from these earlier experiences. Whilst there is no evidence to confirm that during the pregnancy in 2019 and immediately thereafter, the mother was the victim of abuse, exploitation or coercion, it is not unreasonable to begin to raise questions that go beyond what was known and being observed. Data collected¹⁰ by HM Government in 2021, highlights that there are higher numbers of female victims of domestic abuse that are from minority ethnic groups – including black, black African, Asian, and mixed. Although in this sample data shows that white people (5.7%) were more likely to experience domestic abuse than Black (3.7%) or Asian people (3.6%) the figures highlight an important point about the need for increased awareness about vulnerability and risk factors alongside greater professional curiosity. Research¹¹ considers these issues '*...It is crucial to note that while violence against women manifests in various ways across different class and cultural contexts, victims/survivors' experiences of abuse and victimhood are shaped by their intersectional identities and locations ... prior research shows that black & minority ethnic women, who are located at the intersection of numerous structural inequalities, face additional issues and pressures that compound their risks of violence ...*'. Additionally, '*... they are also more likely to experience inappropriate professional responses from statutory and voluntary agencies ... [such as] ... lack of coordination, failures in multi-agency cooperation, high levels of stereotyping regarding their identity ... and race ...*'. Whilst the mother's previous experiences of abuse and exploitation were not known about at the time, the intersecting factors for the mother where additional professional curiosity could have been applied at the time, had there been a settled period to conduct a full assessment included; what her race and ethnicity meant for her current circumstances, the extent of her mild learning difficulties/disabilities and how this impacted on her capacity and independence, the circumstances of being homelessness and then being re-housed but out of area near 'family' members, and the background to her becoming pregnant and there being no contact with the father.

¹⁰ Domestic Abuse, Percentage of 16 to 74 year olds who reported being victims of domestic abuse in the previous 12 months, published 26th February 2021, HM Government - [Domestic Abuse](#)

¹¹ Gill, A.K., & Virdee, G., Intersectional interventions to prevent violence against women in black and minority ethnic communities, p. 136, in Working with domestic violence and abuse across the life course: understanding good practice, Thiara, R.K., & Radford, L., 2021, Jessica Kingsley.

- *Multiple moves* – As the mother moved frequently this inevitably impeded the ability for any one professional to form a meaningful or trusting relationship with the mother and in turn, conduct a thorough assessment of risk to the unborn child. A further complicating factor was the moving back and forth between areas, thereby significantly hampering the smooth and efficient handover of care from one professional to another. Research¹² supports the importance of continuity of care to help build trusting relationships, especially with midwives, social workers and health visitors during pregnancy. Perceptions about stigma, fear of being judged negatively or referred to statutory agencies, not disclosing or explaining the true nature of difficulties faced are all factors that may play on the minds of women that are pregnant, and who have additional vulnerabilities. It will be important for Housing authorities to keep this in mind when conducting suitability assessments for those deemed homeless, alongside fulfilling their statutory obligations in dealing with the homelessness aspect.

5. Learning & recommendations

5.1. As noted in section 1.2, learning and actions were identified following the initial Rapid Review in December 2019. Learning at that time, which also translated into a Partnership Action Plan, included:

- a) Practitioners should ensure that they give equal consideration to an individual's vulnerabilities, welfare needs and housing needs.
- b) Information sharing between Local Authority areas, when there is a high volume of information can result in a loss of meaning to a person's background.
- c) Local authority area thresholds may not align, which means that a person's assessed needs translate to a lower threshold than a previous assessed need, with a different local authority.
- d) It is important of 'look beyond the obvious', to gather as much information.
- e) Increasing awareness of cultural needs is important when someone refers to an 'aunt' it may be someone from the community and not a family member.
- f) A perennial challenge was also identified about how professionals obtain high quality, relevant and accurate information when families move across multiple Local Authorities in a short period of time.

5.2. Information gathered at the Rapid Review stage also highlighted a learning point about the challenges often associated with identifying bruising on a baby's skin when skin colour is darker. Whilst not considered to be a justified line of enquiry in this particular case, given confirmed information about Baby Elizabeth having significant skin care needs but also there being no evidence of any safeguarding related concerns, it does serve as a reminder about such challenges¹³ and the need to remain alert to identifying bruising.

5.3. From this review, the following recommendations are made for the Partnership in order to reinforce some of the above learning points made in 2019, but also strengthen the local response to families that are either transient between local authority areas, or are re-housed from other authority areas, and where there are concerns about risk or vulnerability.

1. Given the passage of time since the initial learning was identified at the Rapid Review stage, the Partnership should test how effectively points a), and c) have been taken forward into practice and gain an understanding about how vulnerabilities, welfare needs, housing needs and thresholds are interpreted for new referrals – especially for those into Telford from other local authority areas. The underpinning focus of testing the effectiveness of these two areas should be the welfare of the child/children. The assessment of factors such as race, ethnicity, culture and language should be included in the assurance exercise.

¹² Mason, C., Robertson, L., Broadhurst, K., Pre-birth assessment and infant removal at birth: experiences and challenges – a literature review, 2019, Nuffield Family Justice Observatory.

¹³ Royal College of Paediatrics & Child Health, Child Protection Evidence: Systematic review on bruising, March 2020.

2. The guidance offered in the Regional Child Protection Procedures for West Midlands relating to Protecting Children Who Move Across Local Authority Borders (revised 2013) and the policy Children and families moving across local authority boundaries (1.16) should each be reviewed to ensure they more adequately cover unborn children/pregnant women. The Partnership should raise this within the regional safeguarding meetings that take place. In addition, the Partnership should ensure that local policies and/or procedures are in place setting out the steps to be taken when informed of a family that has relocated into the Borough.
3. Telford & Wrekin Safeguarding Partnership should reinforce the need to ensure good quality information is being recorded in relation to service user demographics and protected characteristics, where such information is relevant to the welfare and safeguarding of the child/children. This should also include gathering information about all parents of children or those in a parenting capacity (e.g. step-parents, same sex parents, biological parents). This is with a view to improving recording of such information to enable practitioners to exercise greater professional curiosity when meeting with children and their families/carers, and when undertaking assessment activity.
4. Where such data is available, the Partnership should assess whether or not there are any households comprising children or pregnant parents that have been rehoused within the borough of Telford & Wrekin where those families are assessed as needing help and/or protection as a result of risks to their health or development e.g. where children might be considered children in need, on child protection plans, are looked after children, young carers, disabled children or are in need of early help. Practitioners and partner agencies (such as housing authorities) should be reminded of the need to ensure good quality information is provided by referring Housing Authorities about the composition of the household being located within the Borough, the quality of assessments completed by the originating Local Authority, information provided particularly in relation to households in need and the rational for placing in the Borough. It is recognised that the Partnership has asked the National CSPR Panel on more than one occasion to consider this issue, has written to the LGA, ADASS and ADCS to seek national recognition of the need to improve information sharing in these circumstances. It is recommended that the Partnership repeats these endeavours.