HERTFORDSHIRE safeguardingchildren BOARD

SERIOUS CASE REVIEW

CHILD I

Independent Author: Dr Russell Wate QPM
January 2019

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1. Introduction

1.1 This Serious Case Review (SCR) was commissioned by the Hertfordshire Safeguarding Children Board following the death of the subject of the review, CHILD I. At the time of his death CHILD I was under one year old.

1.2 On the day of his death in April 2017 CHILD I was left in the bath with his older brother (who was under two years old) by his mother while she looked for clothing and started to prepare breakfast. On her return she found CHILD I lying in the bath. The SCR has received different accounts as to his exact position and it is not certain how long the children were left for. The children's father was in the vicinity but says that he did not know that anything untoward had happened until the mother returned and screamed in distress.

1.3 The mother removed CHILD I from the bath and emergency services were called. CHILD I was taken to the local hospital where extensive resuscitation was undertaken. Despite these best endeavours medical staff were unable to save CHILD I.

1.4 The police described the conditions in the home as neglectful (further details are given in paragraph 8.21 – 8.22). This caused immediate concern as to the ability of the parents to care for CHILD I's sibling. Child I's sibling and an unborn baby were subsequently made the subject of a child protection plan. No criminal charges were brought as taking account of the circumstances as a whole Hertfordshire Police decided that this would not be in the public interest.

1.5 A referral was made to the Hertfordshire Safeguarding Children Board. Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) defines a serious case as being one where: (a) abuse or neglect of a child is known or suspected; and (b) either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. In this case CHILD I had died and the SCR panel believed that the children had been living in neglectful circumstances.

1.6 On 5 July 2017 the Hertfordshire Safeguarding Children Board Panel made a recommendation to their Independent Chair that a Serious Case Review should be undertaken in this case. The Chair agreed with this recommendation.

2. About the Author

2.1 The Hertfordshire Safeguarding Children Board commissioned an independent author to carry out the review. The review is supplied by RJW Associates and the lead reviewer is Dr Russell Wate QPM. He is a retired senior police detective, who is very experienced in the investigation of homicide and child death and child

neglect issues. He has contributed to several national reviews, inspections and inquiries, as well as being nationally experienced in all aspects of safeguarding children. He has carried out many SCRs and is also an independent chair of two LSCBs. He has no connection with and has never worked in Hertfordshire.

3. Terms of reference / Scope including time-frame to be covered

3.1 The subject of the review is CHILD I (under one year old).

3.2 The focus and key issues that this review sought to address were as follows:

- To review the circumstances leading to the death of CHILD I and establish what lessons are to be learned from the case about the way in which local professionals and organisations worked individually and together

- To establish what lessons are learned to safeguard and promote the welfare of children and by doing so act upon these lessons swiftly, identifying the need for change where appropriate

4. Methodology

4.1 Working Together 2015 allows Local Safeguarding Children Boards (LSCBs) to determine their own processes for review. The Case Review Group of the Hertfordshire Safeguarding Children Board formed a panel to manage the review process. The panel was independently chaired and consisted of senior managers and safeguarding specialists from agencies from the area. The role of the panel was to assist the independent author and reviewer in considering what lessons could be learned and developing recommendations to improve policy and practice to better safeguard children. The panel details:

Keith Ibbetson, Independent Chair
Russell Wate, Independent Author
Safeguarding Boards Manager, HSCB
Detective Chief Inspector, Hertfordshire Constabulary
Named Doctor, West Herts Hospital Trust
Designated Nurse Safeguarding, East & North Herts CCG and Herts Valleys CCG
Head of Family Services Commissioning, Herts County Council
Named Nurse Safeguarding Children, Herts Community NHS Trust
Consultant Safeguarding Nurse (Named Nurse) Herts Partnership Foundation Trust
Strategic Project Manager, Borough Council
Senior ASB & Fraud Officer, Community Housing Trust

4.2 After understanding which agencies had been involved with the family, management reports and chronologies were requested from the below listed organisations. Where possible report authors spoke to staff within their organisation who were involved in the case.

Hertfordshire Constabulary
West Hertfordshire Hospitals NHS Trust
Borough Council
General Practitioner
Hertfordshire Community Trust
Hertfordshire Partnership Foundation Trust
Community Housing Trust

4.3 The methodology applied to this review has been a "blended methodology" utilising the rigour of a chronology and management reports from each agency, with the review author's analysis. The review was then supplemented by a thorough practitioner workshop. It is good practice for an Overview Report to have input from professionals who have been involved in the case so as to test out the material gathered and to try and answer the 'why' questions. In this review it was particularly helpful, and helped to add context, content and richness to both the report and also the learning. The review author also spoke to both the mother and father, gaining their unique perspective.

5. The family

5.1 The mother and father are of black African heritage having both originally come from Southern Africa. At the time of CHILD I's death, they had two children and the mother IM was pregnant with their third child who has now been born.

Father of Child I	IF	
Mother of Child I	IM	
Sibling of Child I	IS	Under 2*
Subject Child I	CHILD I	Under 1*
Sibling of Child I	IS2	Unborn*

*Age at time of CHILD I's death

6. Contact with the family

6.1 It is essential where possible that reviews obtain the views of family members. As part of this review IM and IF were seen and given the opportunity to express their views on CHILD I's death and their family circumstances that led up to it. Understandably they found talking about CHILD I difficult. The parents are understandably distressed that they are having to discuss their loss again after almost a year and feel that, although they will never get over losing the baby, they

need to move on and that they feel these processes are impacting upon them emotionally. To the extent to which they were able to convey them to the reviewer their views are reflected throughout this review.

7. Background

7.1 The mother IM arrived in the UK in 2002, as an asylum seeker from Southern Africa. IM reported suffering traumatic experiences whilst living in Southern Africa. They were of immense significance to her but to protect her privacy they are not described in more detail here. She lived with an aunt in another area in the UK until November 2003 before moving to Hertfordshire.

7.2 IM resided in hostel accommodation and in 2003 there are indications that she suffered some mental health illness. She was admitted to hospital and later being detained by police under s136 of the Mental Health Act.[1]

7.3 During 2005, IM was involved in an appeal process regarding her immigration status, and at this time enrolled on a college course to train as a mental health nurse.

7.4 In 2007, it is recorded that IM's disorder had resolved and after a phone consultation she was removed from her GP's 'severe mental illness register' of patient's subject to mental health care plans. IM was still regarded by the GP practice as someone who needed checking for her mental health but not on their register. This consultation was carried out on the phone. It is known that IM had failed to attend two appointments in 2006.[2]

7.5 In 2008, it was documented in the GP records that IM had felt well and stable for some time. She had finished her initial college course and was due to attend University. IM stated that she was continuing with her medication, but the GP records do not support this as her last prescription had been in 2006.

7.6 It would appear that IM wished to have no further contact with psychiatric services after this point. The GP surgery sent letters to IM in 2008 and 2009 inviting her to the surgery for a mental health review but received no response. It was suggested at the practitioner learning event by a GP that where a person is suffering from mental health issues, it is important to ask consent for a family member or friends details to be given so that in the event of no contact there is someone else to contact to ensure they are no mental health issues that need addressing. This was

[1] At the time mental health legislation gave the police the power to remove a person who appeared to be suffering from a mental disorder from a place to which the public had access and take the person to a place of safety. These powers have subsequently been extended by Section 80 of the Policing and Crime Act 2017.

[2] It is not possible to provide more detail of these episodes because the mental health records were destroyed in a fire and cannot be accessed.

seen by the review author and agreed by others at the practitioner event as good practice, as was the sending of the letters in the first place.

7.7 In 2011, the GP had a further telephone consultation with IM and reported conducting a 'mental health review'.

7.8 IM and IF are not married. IF had also entered the UK as an asylum seeker from the same African country. The first records for IF are in 2004 when he registered with his GP**.** There are few records of contact from agencies with IF after this time. Several years before becoming a parent he had been arrested for offences of dishonesty and was charged with sexual offences, but not convicted.

7.9 In March 2013, September 2013 and April 2014 IM became pregnant, but on each occasion lost the unborn baby at various stages of pregnancy. The second of these pregnancies resulted in IM giving birth to a baby who survived only very briefly. When IM presented for the last of these pregnancies at 4 weeks she was told to self-refer to maternity services.

7.10 IM and IF attended what is described in records as a small African church in North East London. It is located more than 20 miles from the family home.

8. Birth of IS and CHILD I

8.1 In early January 2015, IM attended her GP, pregnant with IS. A referral was made to maternity services, but details of her mental health history and the outcomes of her previous pregnancies were not included in the referral.

8.2 IS was born prematurely at 26 weeks in April 2015, at a hospital in another area with IM having been transferred there from their local hospital. IS remained in various hospital neonatal units until finally being discharged in mid-August 2015.

8.3 Throughout 2015, IM was being dealt with by the Housing Department for unpaid Council Tax resulting with a summons being issued in August 2015. In June a letter was sent by the Housing Department for Breach of Tenancy due to an untidy garden.

8.4 IM presented as pregnant with CHILD I in October 2015. Again, when the GP referral to hospital maternity services was made there was no mention of the previous mental health issues or the previous difficult pregnancies.

8.5 In October 2015 a home visit was made by the local children's centre to discuss what services they were able to offer**.** This is common practice and there is no record to indicate that this was because of any professional concern.

8.6 In October 2015, the police attended a domestic dispute at the family home. A neighbour reported hearing shouting and screaming coming from 'the flat upstairs' in which a child also resided. The police found IF to be drunk and in a fracas on the

doorstep he assaulted two police officers and was arrested. The officers attending had concerns over the new-born child because they found no food that they believed was of a decent quality for the child and the address was dirty and unhygienic. There is no information on what risk assessment was made because of this incident and IM was pregnant at this time and had a young child. Despite identifying and recording these concerns and categorising the event as a non-crime low risk domestic incident the officers involved made no referral to the local authority. It has not been possible to establish why this oversight occurred. IF was subsequently convicted of assaulting the two officers.

8.7 In late October 2015, IM failed to attend a clinic baby check appointment but shortly after did attend a local baby massage group. This was the only session that she did attend but it does demonstrate contact with some of the local community support that was available.

8.8 In November and December 2015 IM attended two further baby clinic appointments with IS before informing staff that she would be travelling to Southern Africa in December 2015 to visit family.

8.9 In February 2016 IM failed to attend a neo-natal appointment for IS, a letter was sent to the GP to highlight the non-attendance. Two days later IM did attend a scan for her pregnancy which was normal. In March 2016, IM did attend the neo-natal clinic with IS and he was noted to be making good progress.

8.10 In April 2016 CHILD I was born at 37 weeks of pregnancy, the following day IM was discharged to the care of the community midwife. At the time of CHILD I's birth IS was one year of age. IM and CHILD I were seen by the community midwife until 10 days after the birth. There are no recorded concerns at this time over the care given to the children or the state of the family home. There had been a lot of antenatal care and appointments for IS due to their prematurity during which there were no concerns.

8.11 In May 2016, the Health Visitor (HV) made the first new birth visit. The examination of CHILD I was recorded as satisfactory. A broken window was noted and an explanation for this was given. The family said that they were to be re-housed due to a neighbour dispute. No Domestic Abuse screening took place due to IF being present throughout the visit. CHILD I was noted to be sleeping with IM as the cot needed to be assembled. Safe sleeping advice was given and two days later the HV visited again to ensure the cot was in place.

8.12 In May 2016, IF attended the GP surgery with hay fever he also, discussed being under stress. He stated that he had recently had a baby and that he had a lot of issues at work. He was advised to speak to his work HR department and union. There was no referral made for more specialist assessment in relation to the reported stress.

8.13 In June 2016 the HV saw IM with CHILD I and IS, on this occasion the Domestic Abuse screening questions were asked, and the answer given to each was 'no',

indicating that there was no domestic abuse present. IM kept her GP appointment for routine immunisations. Health professionals had no knowledge of the police attendance at the domestic abuse incident.

8.14 In July 2016 the family moved to a new address in the same council area. In September 2016, IS attended a neo-natal clinic with CHILD I and IF, there were no concerns noted.

8.15 In September 2016, IM notified the GP that she would be travelling to Southern Africa, and she would be staying several months.

8.16 Although there are no records of exactly how long IM was out of the UK, or when she went, from discussion with the family for this review it is known that IM travelled with the children and IF remained at home. When she returned IF had lost his job and IM would state that this is the time that family conditions started to deteriorate.

8.17 In January 2017, IM booked with antenatal services as pregnant, this was a late booking as she was 22/23 weeks pregnant. The late booking was recognised, and information was shared with Children's Services. There is no information to suggest that the GP was aware of this pregnancy previously. IM was booked a consultant appointment due to her previous complications in pregnancy.

8.18 At the beginning of February 2017, IS attended the neonatal clinic with IM, IF, and CHILD I. It was noted that he was making good progress and there were no concerns.

8.19 In March 2017, IS was not taken for his yearly check-up, a text reminder had been sent and the missed appointment was followed up with a phone call to IM, to which there was no response. A letter was sent to re-arrange the check for April 2017.

8.20 In mid-March and mid-April, IM attended a consultant appointment and community midwife clinic respectively for her current pregnancy where no concerns were noted.

8.21 In the morning in late April 2017 ambulance and police attended the home address on the report of a child in cardiac arrest. CHILD I's mother reported that he was breathing, though this is not confirmed by the ambulance service records. CHILD I was conveyed to hospital where resuscitation continued. CHILD I died after approximately one hour. It is not possible to be certain how long the children had been in the bath.

8.22 The police noted the house was in a neglectful condition. The officer describes this as *'The home has 2 bedrooms which identified that the home conditions were in a neglected state. There was evidence of mould to windows and walls. Limited food was in the home and nothing which would be suitable or appropriate for small children. One room had a bed and baby cot and it would appear that IM slept here with Child I. The cot was full of clothes and other items and did not appear to be used for Child I to sleep in. IF and IS were sleeping in the other room, there was no*

bed in this room and appeared they were sleeping on a duvet on the floor. The bedding appeared grubby; there was no cover on the duvet and no pillow. There were piles of clothes in both bedrooms. Soiled nappies were on the floor (and also in mother's bed room). In the kitchen there was an absence of any consumable food. The fridge was rusty with few items inside. It was dirty and unhygienic. Pots of food were on surfaces. It was generally unhygienic and in need of a clean.'

8.23 The next day, a strategy discussion took place in relation to the accommodation of IS. The following day to this an initial information sharing and bereavement planning meeting was held, this was attended by professionals to discuss the case and next actions in accordance with the Hertfordshire Safeguarding Children Board multi-agency procedures[3]. A Home Visit by the Rapid Response Nurse took place in this case. The nurse also noted the neglectful conditions as described by the officer, but went further to say how in her professional view the house and garden were an unsafe environment for the children to be living in.

8.24 IM was pregnant at the time with Child IS2.

9. Analysis of involvement

9.1 IM was pregnant every year between 2013 and 2017. She miscarried on the first three occasions, once very late in the pregnancy. IS was born prematurely and was in hospital for several months at hospitals in Luton and Cambridge. IM travelled by bus almost daily to visit him. CHILD I was then born less than a year after his sibling. This understandably made this a difficult and stressful period for both IM and IF. However, when IM and her children were seen by professionals the evidence was that IM prioritised her child's needs effectively.

9.2 IM has a history of mental illness, this dated back to 2003 and she had received both in-patient and out-patient treatment up until around 2008, when she felt well and no longer sought support from mental health services. There is no evidence that IM's mental health history had any impact on her ability to parent her children. There was though, no communication of the mental health history between the GP and maternity services. Knowledge of this history taken together with the repeated maternity problems that IM experienced may possibly have led to more support being offered to IM. As an example, in April 2014, when IM presented for the third of her unsuccessful pregnancies she was advised to 'self-refer' to maternity services, suggesting that her psychiatric and obstetric medical histories had not been fully considered.

9.3 At the SCR practitioner learning event there was a good discussion about the national and Hertfordshire encouraging 'self-referral' to maternity services, which can happen without the knowledge of the GP. It was felt that in the vast majority of

[3] HSCB Rapid Response Protocol - http://hertsscb.proceduresonline.com/pdfs/cdr_rapid_response.pdf?zoom_highlight=rapid+response#search="rapid%20response"

cases this worked out fine as the medical notes and patients were normally cross referred in due course. However, for a mother with high medical, social or psychiatric risks, advice to self-refer may not have been the best course of action.

9.4 Although there is an understandable desire not to stigmatise pregnant women with past medical history of mental health conditions, there are very strong reasons in this case for GPs to inform maternity services of this potential vulnerability.

9.5 IM and IF were struggling financially and proceedings were being taken against them for non-payment of council tax. Shortly after the birth of CHILD I, IF attended his GP for hay fever but did disclose that he was suffering from stress due to having a new baby and issues at work. When a review author met IF, he would seem a relatively private individual and his infrequent access to services would tend to support this as being his personality. It may have also been that he was not confident to talk to people he doesn't know. This disclosure regarding stress may have been a 'cry for help' and he may have benefited from a referral for support to further explore his stress. The SCR practitioner learning event considered whether the mother might have been referred (for example for community based mental health support) in similar circumstances, so maybe this should have taken place for IF.

9.6 IM and IF did not have a geographically close family network on which to rely. They did seek and receive support from their church although at that time (early 2016) this was not on a regular basis. There is no evidence that the church was aware of the financial and practical difficulties facing the family as they were not always regularly in attendance there. IM visited Africa with the children in December 2016 and she told the SCR that when she returned she found IF had lost his job and it was from this time that the home conditions started to deteriorate.

9.7 As a family with two young children health practitioners made fairly regular home visits, but there were no recorded concerns about home conditions, so it is reasonable to assume that it was around this time the neglectful conditions witnessed by emergency staff in April started to prevail. The normal pattern of health visiting contact specifies a home visit at about 10 months to 1 year. The community health records state that a clinic appointment was given but that the children were not brought. This could have instigated a home visit but it is not clear if there was a plan to do this or not.

9.8 There was a pattern of some other missed health appointments, so consideration must be made to 'Did not attend' procedures, however, in this case, these were interspersed with attendances, so wouldn't have given rise for concern for the children. An example of this where the whole family attended an appointment in February 2017 and IM attended appointments in March and April. It could not be said that the family were conspicuously trying to avoid services. On the face of it their fluctuating attendance gave no cause to concern professionals.

9.9 There is evidence that extended universal services were offered to the family with a visit made by the children centre. This may have been the catalyst for IM to access

baby massage with CHILD I. Although IM only used this service on one occasion it does show that she was aware that there were services available to support her and the family.

9.10 The SCR has considered whether the family's ethnicity and position as asylum seekers may have affected the parents' ability to access services or the response of agencies. The family come from a country which has strong links with the UK and many migrants and asylum seekers. Many of its former residents thrive in the UK, making an important contribution to services such as the NHS. This couple did not thrive. The mother experienced mental health problems and appears to have been treated and supported successfully. However, her plans to work as a nurse did not come to fruition. Less is known about the father's background and history.

9.11 Conversations with the family suggest that they were isolated from family and community support and even their links with their church were not frequent. They donated money to the church but its members were not aware in detail of their difficulties. They may have wanted to participate as full members and not appeared to have been dependent. Both parents spoke fluent English and lived in a part of Hertfordshire that has a substantial minority ethnic population, including many other Black African families with young children.

9.12 The family received specialist medical services in hospital and universal services in the community for IS. In both settings it will have appeared that the mother was focused on her children and coping with her son's health difficulties. It appears that no additional efforts were made to encourage engagement in services that could have assisted. She went once to a baby massage session but no one asked why she stopped attending. On paper the father had a troubled history with the police, though he did not acknowledge this as a major consideration. The SCR has noted that his response to the police attending his house might have been influenced by his experience of government interventions in his life in his country of origin.

9.13 Whilst all of these factors may have been significant, as a family that largely received universal services and coped well, it is unlikely that any professional would have had the opportunity or felt the need to probe their significance more deeply . However, if a more comprehensive picture had been available someone might have explored these questions.

9.14 IM did state that she thought she would have benefitted from the parenting course earlier which she has undertaken since CHILD I's death for her other children. She described the course as 'awesome' (a tribute to those that deliver this course, and good practice), but states that she would not have known how to access it, when either IS or CHILD I had been born.

9.15 There was evidence of one report of domestic abuse in the relationship with one incident being reported to the police in October 2015. At this time IM had a young baby (IS) recently released from hospital and she was pregnant with CHILD I. A neighbour had called the police after hearing shouting from the flat upstairs. When police attended IF assaulted two officers and was arrested. A line of enquiry that the

review author was asked to consider by the SCR panel, was whether IF was violent and controlling. There is no clear evidence to suggest this following information to the review from agencies, the social work team currently working with the family and conversations with the family themselves. This possibility cannot however be entirely discounted.

9.16 The Police on attendance did have concerns about the state of the house and felt it was neglectful. They did plan to report this to Children's Services but did not. Information now provided to the review is that there is in Hertfordshire (as elsewhere in the UK) a very large number of referrals are made about children in families where there have been domestic abuse concerns. Since 2015 systems have changed so that information about these referrals is passed to schools and health professionals as well as the local authority. Housing providers are not currently included in this arrangement and they lose the opportunity to visit families and provide services.

9.17 When a woman is pregnant there is a higher risk from domestic abuse. Information in this case was not shared with other agencies because of an oversight on the part of the officers. However, there is no indication that this is a wider problem in Hertfordshire and in fact the main challenge facing some agencies is processing and risk assessing the large number of referrals that are made.

9.18 The housing service had a high level of contact with the family primarily about the continuous failure to pay the rent. However, no home visits were made. Had this happened there may have been opportunities to identify the neglect that was building up after IF had lost his job and IM was pregnant again. Professional curiosity by thinking how the family coping with two very young children was when unable to pay the rent may have helped.

9.19 CHILD I did die from a drowning incident in his household bath. It is fully accepted by all including the review author that this was a tragic accident, and fully understand the family's feelings that they are trying to cope with the impact of this. As part of the learning from this case there should be a re-emphasis to parents of young children of the dangers of leaving them unattended while bathing them.

10. Learning from this case

10.1 Although this was a family that were only known to universal services there are some indications that could be considered for future learning.

- Housing providers may have indications that give rise to concern that families with young children, are starting to struggle and may benefit from more support. In this case it is not clear whether any additional support would have been accepted by this family at the relevant and crucial time. Housing providers told the SCR that they often feel that important updates including safeguarding information are not shared with them. In this case they believed the family had one child and did not know about police contacts. The SCR was told that professionals in other agencies often do

not know what housing providers can do to help vulnerable families. This is something the partnership could develop further. As an example, Housing providers and District and Borough Council Neighbourhood Officers who complete home visits and speak to tenants should always receive an agreed level of safeguarding training in identifying child neglect issues and ensuring that staff are aware of the relevant reporting mechanism. Housing officers should be encouraged to be more proactive in such matters.

- The SCR author has been told of an initiative that will hopefully improve this working together. Locally Police and housing providers attend a monthly meeting known as the Community Protection Group (for information sharing). This provides officers with an opportunity to discuss any cases and concerns (including safeguarding) in relation to particular cases and request information, advice or support from partners, agencies and or other services around the table. Any cases of concern which need on-going monitoring and multi-agency support are placed on Safety Net, accessible to all partners and agencies for input as part of the Community Protection Group. Health professionals do not attend the Community Protection Group meetings, however the importance of health's attendance at these meetings is vital.

- The review has noted that the family might have benefited if greater consideration had been given to needs to a range of background social factors, for example the family's ethnicity and apparent isolation, the mother's historical mental health concerns and their status as asylum seekers, and how their cultural background and previous experiences might need to be taken into account by those providing services. Also, if these factors could leave them isolated within the community they live in. The family themselves stated they were just very private individuals and would not describe themselves as isolated or that their home life situation was grim.

- There needs to be good communication between GP and maternity services to ensure that information on issues such as previous parental mental health and details of previous pregnancy complications is shared at an early stage to allow for the appropriate support to be given.

- Health professionals referring for and providing antenatal care should give consideration to mothers who have suffered multiple miscarriages and then become pregnant, especially if pregnancies follow in quick succession. Prematurity will in this context in particular increase the stress felt by parents with a new baby.

- There is already wide cross agency sharing of domestic abuse information and the systems in place have been reviewed since the events described in this review. The review of the effectiveness of such systems should be continuous.

- In July 2017 following the death of Child I and the Rapid Response process that was instigated at the time of the death, a decision was made to commence a water-safety initiative. The health visiting teams across the county were asked to discuss and share the HSCB water safety leaflet at every child's next developmental assessment for the next year. This will be extended for another year. The leaflet will be handed to all new mothers at new birth visits through to the age of 1 year. Health commissioners should establish how effective the recent Water Safety Initiative has been.

11. Recommendations

The HSCB should seek confirmation that recommendations and areas of improvement identified by agencies in their own reviews have been implemented.

Recommendation 1
The HSCB should seek assurance from health providers and commissioners that any social and medical risk factors in pregnant woman are communicated effectively to maternity services by GPs and that the growth in self-referral does not hinder this.

Recommendation 2
The HSCB should seek assurance from the police that their procedure for responding to any incident of domestic abuse ensures in practice that all relevant information is shared with partner agencies through the current processes that exist. This includes the Domestic Abuse Investigation and Safeguarding Unit (DAISU) and where appropriate if the notification meets threshold this will also be undertaken via the Multi Agency Safeguarding Hub (MASH).

Recommendation 3
The HSCB should seek assurance from housing commissioners that their own staff and those of housing providers, in particular those who make home visits, receive suitable training in recognising and responding to concerns about vulnerable adults and children. This should take account of the needs of families with small children who fall into arrears.