‘Franklyn’

Child Safeguarding Practice Review

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1. Introduction by the independent author and rationale for the local child safeguarding practice review

This Local Child Safeguarding Practice Review (LCSPR) concerns Franklyn. The Merton Safeguarding Children Partnership would like to offer sincere condolences to Franklyn's family.

Franklyn was born with a life-limiting disability and complex health needs. Following the death of Franklyn in hospital at the age of four and a half months, the Merton Safeguarding Children Partnership agreed to undertake a Child Safeguarding Practice Review following the completion of a rapid review, which took place over two meetings. The rapid review identified areas of learning that would be taken forward by partners. The areas for learning included, the need to acknowledge factors that may impact upon a parent's ability to fully understanding the seriousness of their child's medical condition, potential improvements in hospital discharge preparation and planning, considerations for future commissioning of home support, improved communication for care staff by the care agency and learning in relation to the impact of the pandemic. The rapid review highlighted some wider learning for the partnership that would be taken forward through this review. The key lines of enquiry identified were communication, the family's voice, commissioning of services and disproportionality. The key lines of enquiry were expanded following the meeting of the panel who oversaw this review (see section 3 below).

"The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving" (HM Government 2018).

Serious child safeguarding cases are those in which:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed. Serious harm includes (but is not limited to) serious and/or long-term impairment of a child's mental health or intellectual, emotional, social, or behavioural development. It should also cover impairment of physical health. This is not an exhaustive list. When making decisions, judgment should be exercised in cases where impairment is likely to be long-term, even if this is not immediately certain. Even if a child recovers, including from a one-off incident, serious harm may still have occurred." (HM Government 2018)

Given Franklyn's age and complex needs, much of this report focuses on the experience of his mother and those professionals whose role it was to advocate for and safeguard him. The report seeks to improve practice in the support and safeguarding of children born with complex needs. With this end

in mind, it is the learning from this case that gives us a window as to how we can learn from the examples of good practice, and reflect upon any difficulties that arose between professionals, or for Franklyn's mother and her wider family, in his safeguarding and support.
Throughout the time that the review was undertaken there was an ongoing police investigation and therefore this review has made no reference to the potential cause of death nor the circumstances in the immediate period prior to the death. The review has focused on learning for the wider system to support safeguarding practice for children whose lived experience was similar to that of Franklyn.

The final report has been authored by Dr Amanda Boodhoo who was independent of the case with no actual or perceived conflict(s) of interest.

Case summary

The report reviews the case of Franklyn who had complex health needs. Franklyn died in hospital aged four and a half months, having suffered an out-of-hospital cardiac arrest. Franklyn's mother had left the home the night before, leaving Franklyn and his brother asleep, in the care of a professional carer. The terms of the care package meant that Franklyn's mother should not have left the carer in sole care of Franklyn and the carer had no role in providing care for Franklyn's brother. Following the hospital admission, the decision was made for Franklyn to receive palliative care and he died shortly afterwards. At the time of death Franklyn had been subject to a child protection plan for seven weeks due to concerns relating to domestic abuse and parental/significant adult substance misuse. (A rapid review and Joint Agency Response has been completed which looked at modifiable factors). This review offers the opportunity for wider learning across the local system.

Names have been changed throughout the report to protect the identity of individuals.

2. Franklyn's Life

This review focuses upon the lived experience of Franklyn. Franklyn was a much wanted and loved little boy who was described as Black/Black British/Caribbean and lived with his mother and older brother, who was nine years older. In undertaking this review, it is important to understand as much as possible about Franklyn and his lived experience in the months before his death, to keep him at the centre of the review process.

In January 2022, Franklyn was born following an emergency Caesarean section following a placental abruption. At the point of delivery Franklyn had no detectable heart rate and was therefore resuscitated. He was admitted to the neonatal unit (NNU) and underwent total body hypothermia which is standard care for hypoxic ischaemic brain injury.

Franklyn continued to be cared for in the hospital for 54 days. As a result of his brain injury, he had four-limb cerebral palsy, and dystonia which required treatment with medication to help with muscle relaxation. He was unable to swallow his secretions and required frequent suction to prevent aspiration. He had severe gastroesophageal reflux disease which put him at risk of aspiration, and he was reliant on receiving naso-gastric feeds. He had a partial hearing loss, although this was still under investigation at the time of his death.

Franklyn's mother described him as:

> "a lovely boy" who "wasn't here for that long but through his struggles he was a fighter". "He was my little star boy. He was very much loved".

Franklyn was described by a professional who had been involved in his care as:

> "a small, angelic, precious, and gorgeous little boy. He was loved and adored by all including his mother, brother and all his family. He needed a lot of care due to the complexity of his needs. He was a very content little boy and would cry to express himself including when he was upset. He would respond to musical sounds and the sound of his mother's voice. He loved to be comforted and soothed by lots of hugs and affection. He will be missed and touched the hearts of many people".

Franklyn was discharged home and received care from his mother and through a team of carers from a care agency. Franklyn had a life-limiting diagnosis, and was expected to die in infancy, so this time at home was very precious.

Following discharge, Franklyn was readmitted to hospital on several occasions.

Franklyn was seen at home by a health professional the day before his emergency hospital admission. The health professional described several family members and other professionals being present. The health professional stated:

> "Mother was relaxed, chatty and clearly very happy to have Franklyn home".
>
> "At the visit Franklyn seemed calm and settled and he was lying supported on a specialist "cushion". He lay still, with his eyes closed and you could hear the secretions. He needed suctioning during the visit which mother did with confidence placing him on the cot for suctioning. For one brief moment, he opened his eyes much to everyone's delight. He was very much the centre of attention".

At the visit, mother engaged in a conversation with professionals about Franklyn's medication and timings of his night-time medication. Mother wished to arrange for the family to have a short break. This had previously been discussed at a core group as something positive for the family in terms of memory-building, particularly for mother and his sibling.

Given Franklyn's needs, the health professional recognised that arrangements for the break would be challenging, but not impossible, and immediately completed the referral to the family holiday association.

Mother also had a discussion with the health professionals about the possibility of reducing Franklyn's care hours, so that she and the family could have more time with him without carers/professionals constantly in the house. The professionals advised mother that it was in both her and Franklyn's

interests to work with the agreed care package, as he had just been discharged and everyone was still settling and adjusting to being at home.

The day following the visit Franklyn was taken to hospital with his mother after having suffered a cardiac arrest at home. The ambulance team had achieved return of circulation in the community; however, Franklyn remained very unwell, was not breathing for himself, and needed support to maintain his blood pressure. An endotracheal (breathing) tube was inserted, and he was placed on a ventilator. He required resuscitation with fluid to increase his blood pressure. He was given sedation and pain medication to keep him comfortable and help him to tolerate the interventions required to maintain his life.
A scan of Franklyn's brain showed a devastating brain injury owing to hypoxia, a lack of oxygen, as a result of cardiac arrest. This brain injury was irreversible and was likely to worsen his existing dystonia and seizures, he would be likely to deteriorate further and experience pain as a result of the interventions required to keep him alive.

Franklyn's mother agreed that it would be in Franklyn's best interests to stop intensive medical intervention. Franklyn's breathing tube was removed with consent. He died peacefully and swiftly after this in his mother's arms, with his extended family present.

3. Methodology and agencies involved.

The approach I have taken for this case is a focused review. This means that I have concentrated on the specific issues identified in the terms of reference, set by the Merton Safeguarding Children Partnership. As the review progressed, the key lines of enquiry were amended to include emerging themes. Some aspects considered at the start of the review have changed significantly as I have engaged with a range of practitioners who have worked closely with Franklyn and his family.
The methodology for this Local Child Safeguarding Practice Review is outlined as follows:

1. **Examination of chronologies** to establish significant events and key practice episodes.
2. **Analysis of Individual Agency Management Reports** (IMRs) to gain an understanding of the key practice issues, including enablers and barriers to effective practice. Of particular interest in this review are:

   - **Trauma-informed practice**
     How did mother's previous and ongoing trauma experiences impact on how agencies worked with her, and on her own capacity to understand Franklyn's condition and support him?

   - **Family's Voice including hidden men and the role of the family.**
     What was the lived experience of Franklyn and his family, and the impact on them of how services worked together, particularly in relation to Franklyn's health and safeguarding needs? Did partners fully understand and engage with wider family networks in safeguarding Franklyn, including understanding who Franklyn's biological father was?

   - **Disproportionality, inequality, and access to services**

Did mother's ethnicity have any impact on how services engaged with the family? Or were there other factors, such as financial vulnerability, that impacted on services' engagement?

- **Communication**
  To consider the way in which agencies communicated with one another in identifying the safeguarding plan for Franklyn, including escalation processes in cases of professional disagreement.

- **Commissioning of services**
  What processes are in place to ensure effective commissioning of services for children with joint interface of complex health needs and subject to Child Protection processes?

3. **Exploration of themes with practitioners and senior leaders**.

4. **Engagement with Franklyn's family members** to understand their lived experience and gain their perspective on how services worked with them.

5. **The learning from the IMRs, practitioners' events, and family contact** are summarised in the overview report, identifying key themes, highlighting specific learning, and making recommendations for system-wide practice improvement. The review focuses on the period from 1st August 2021 to 30th June 2022. The production of this local child safeguarding practice review has been overseen by a panel with representation from key agencies, and was chaired by Keith Shipman, Head of Service, Education Inclusion.

The agencies involved in the review were:

- Central London Community Healthcare NHS Trust
- Princess Royal University Hospital Trust
- St Georges NHS Hospital Trust
- Epsom and St Helier University Hospitals NHS Trust
- NHS Southwest London Integrated Care Board (formerly known as Clinical Commissioning Group [CCG])
- Southwest London St Georges Mental Health Trust
- GP
- Barmat Healthcare
- Nursing Direct
- Early Help, LBM
- Children's Social Care, LBM
- Education Inclusion, LBM
- Housing Needs and Strategy, LBM
- SEND Team, LBM
- Police
- Victim support
- Sibling's School
- Shooting Stars Hospice

- London Child Death Overview Panel

Expert advice was sought from the BME forum and Kids First. In addition, the partnership received expert advice from the Child Safeguarding Practice Review Panel, which was incorporated into the review.

4. Family involvement

At the commencement of the review, an initial letter and information leaflet was sent to Franklyn's mother, to advise her of the review and to invite her to contribute. It is recognised that the prospect of revisiting the fact of a child's death would be traumatic, and the panel wanted to allow Franklyn's mother time to consider whether she felt ready to revisit the period leading up to the death of Franklyn. In November 2022 the social worker was provided with written communication to share progress with Franklyn's mother, and at this stage she expressed a wish to share her views to inform the review.

The author contacted Franklyn's mother to introduce herself and Franklyn's mother expressed the wish to contribute to the review but requested that this took place after Christmas 2022.
Following the Christmas period, the author made further contact with Franklyn's mother and arrangements were made to have a conversation so that the family's voice could be heard.
The conversation took place. The reviewer would like to acknowledge the very valuable contribution made by Franklyn's mother so near in time to his death.

As the criminal investigation was ongoing at the time of the review, the author continued to liaise with the police to ensure any areas of discussion that arose when meeting with the family would not compromise the investigation.

5. Key practice episodes

August 2012 – June 2021
This period was outside the scope of the review. During this period Franklyn's mother and her partner came to the attention of the police on twelve occasions including domestic abuse, drug-related, and benefit-related incidents. In 2012 Franklyn's sibling was born.

June 2021 – January 2022
This period covers the period between Franklyn's mother booking antenatally and the birth of Franklyn.

Franklyn's mother attended the GP for an antenatal booking appointment in June 2021, and then attended a hospital booking appointment at which her partner accompanied her. At this time professionals had understood this male to be Franklyn's father, but it was later confirmed he was not the biological father. Prior to the pregnancy being confirmed, Franklyn's mother was under the care

of a fertility clinic and had a history of recurrent miscarriages. At the booking appointment mother reported not drinking any alcohol, that she had stopped smoking and denied any substance abuse. Domestic abuse routine enquiry was undertaken, and no history of domestic abuse was disclosed. Mother did not disclose any previous social care involvement or previous alcohol misuse, although this was noted in the GP referral. At the booking appointment mother declined to name the father of Franklyn. Mother's partner reported to the Community Midwife that he had three children but declined to give any details.

This period was one of disruption and gives some insight into Franklyn's mother's experience of trauma and loss. During this period Franklyn's mother lived in three different geographical localities, covered by three different local authorities. The house moves were in response to the experience of domestic abuse from her partner, which resulted in the discussions in the Multi-Agency Risk Assessment Conference (MARAC) in two areas. In the second area she lived in, she received support from an Independent Domestic Violence Advisor (IDVA) but although offered this service, there was very limited engagement when she moved to the third area, Merton. There is evidence, following the move to Merton, of the provision of comprehensive information regarding available support services being given to Franklyn's mother.

In this period Franklyn's mother was registered at three different GP practices, attended two hospitals, and had involvement with three Children's Social Care departments. Evidence of the trauma experienced is discussed in Theme 1 below. In transferring from one hospital to the other for antenatal care there are some missed appointments, but this needs to be considered within the context of her experience of domestic abuse and the disruption of relocating again during a pregnancy whilst parenting a school aged child as a single parent.

Franklyn's mother moved to Merton through the housing association transfer process. Following the house move Franklyn's mother self-referred to Merton Children's Social Care, advising she was now permanently residing within Merton. Franklyn's mother openly shared the history of social care involvement in the previous area. She disclosed being the victim of domestic abuse and that she was pregnant and may need an assessment of her unborn baby as well as financial support. A Child and Family Assessment was completed, which resulted in closure and referral to support services.
Professionals involved following the move to Merton describe how Franklyn's mother was very much looking forward to the birth of Franklyn and describe "a lot of happiness around".

At 37 weeks' gestation midwifery staff had concerns regarding possible cannabis use by Franklyn's mother and her partner. A urine toxicology screen undertaken on Franklyn's mother was found to be positive for cannabis. A referral was made to Merton Children's Social Care raising concerns in relation to the history of domestic abuse, mother and her partner smoking cannabis and non-compliance with medical professional advice. The concerns around non-compliance with medical advice related to two areas; firstly, concerns that Franklyn's mother was not following guidance in relation to COVID-19; and secondly the fact that she had made the decision to stop taking a medication that had been prescribed for the mental health challenges she had experienced. This was a period when COVID-19 restrictions were being relaxed across the United Kingdom and what was presented was advice rather than a mandate. The medication that Franklyn's mother stopped taking was prescribed prior to her move to

Merton. The reasons for Franklyn's mother's decision to stop taking the medication in question are not known. The outcome of the referral was a step down to midwifery and health visiting services.

As the pregnancy progressed Franklyn's mother experienced a number of complications, including raised blood pressure, abdominal pain, pyelonephritis, gestational diabetes, COVID-19, reduced foetal movements and an assessed expected low birth weight. Delivery was recommended at 39 weeks' gestation, and an elective Caesarean section was booked. Prior to the arranged date, mother was admitted as an emergency and Franklyn was born in January 2022.

Franklyn's life, January 2022-June 2022

Immediately following the birth of Franklyn, the midwifery team made a further referral to Children's Social Care raising concerns regarding a strong smell of marijuana and a grinder in the home reported to belong to the partner of Franklyn's mother. Concerns were also raised regarding Franklyn's mother struggling to understand the conversations with health professionals about Franklyn's condition. At this stage the midwifery team were unclear whether Franklyn's mother's partner was the perpetrator of the domestic abuse which had resulted in her move to Merton. A further Child and Family Assessment was completed, which resulted in progression to a Child in Need plan and transfer to the Children with Disabilities team. Following management oversight, a multiagency strategy discussion was recommended. The strategy discussion was held, and all professionals agreed that the threshold for significant harm was met, and the plan agreed to progress to a Section 47 single agency investigation and an initial Child Protection conference. The conference took place in April 2022 with multiagency and family participation and resulted in Franklyn and his sibling becoming subjects of a Child Protection plan under the category of neglect. A robust Child Protection plan was developed.

During this period, the partner of Franklyn's mother was involved in the life of Franklyn and his mother. He was present when mother was admitted to hospital for the emergency delivery and was with her when she visited the hospital. Professionals became increasingly concerned regarding the presence of mother's partner in the lives of the mother and children. The Merton IDVA made ongoing attempts to engage with mother. Mother repeatedly assured professionals that she felt safe. At a later stage the decision was made that the mother's partner should not attend the hospital with her due to his behaviour and the strong smell of cannabis. This was the last point of contact with mother's partner who was a significant adult in the life of Franklyn and would have impacted upon the ability of professionals to include his voice within assessments of Franklyn's needs.

Franklyn's mother desperately wanted to have Franklyn home and it is not clear whether the assurance she gave professionals around feeling safe was to try to expedite his discharge from hospital.

There was a great deal of multiagency activity during this time with ongoing communication, discharge planning meetings and a core group meeting. Plans were being progressed to put in place the services required for Franklyn's discharge, including training his mother in his many care needs. This was challenging as there was a need to coordinate appropriate equipment and a care package. The current housing also posed further challenges as it was considered too small to accommodate the equipment and carers. Although she was assessed and placed into the highest priority group for rehousing, the housing representative advised that there were a number of others with equal priority, which placed

pressure on existing housing stock. Although this was frustrating for the family and professionals supporting the family, this is a challenge that exists in several areas beyond Merton. A further complication arose when the care provider that had been approached to provide care declined to provide the service due to concerns regarding the history of substance use and domestic abuse, which meant another provider needed to be found.

The family were referred to the Children's Hospice in February 2022 prior to Franklyn's discharge from hospital. The request was for ongoing hospice support to assist with symptom management for Franklyn and emotional support for both his mother and older sibling. The hospice maintained regular input and there is evidence of ongoing communication with the family, hospital, and school.

Throughout the time Franklyn was in hospital the extended family and the school provided care and a sense of continuity for Franklyn's sibling. There is evidence that professionals assessed and responded to the needs of Franklyn's sibling.

In March 2022, the health visitor referred Franklyn's mother to an integrated primary care mental health service having discussed the service and obtained consent. The referral was received, was triaged and contact attempted by text and telephone. When Franklyn's mother did not engage, the referral was closed within a week. In discussion with the representative from the mental health provider, it was acknowledged that the referral was of a high quality and given the trauma that Franklyn's mother was experiencing a seven-day window to engage was unrealistic. Assurance was given that the learning had already been taken forward within the organisation.

Several professionals were involved in supporting the family, including the range of hospital and community staff, social workers, therapists and the GP.

In April 2022 Franklyn and his sibling became the subject of Child Protection plans and an urgent referral was made to the Independent Domestic Violence Advisor (IDVA) service.

In May 2022 Franklyn was discharged home from hospital with an agreed package of care; 97 hours funded by the Integrated Care Board and 12 hours by Social Care, all provided by the same agency but with different "rules" as to which element required Franklyn's mother or a family member to be always present, and which part allowed respite.

Franklyn experienced several hospital attendances and readmissions following his initial hospital discharge and a situation arose where there were differing views regarding the level of qualification required of his carers, with the current agency believing trained nurses were required. The outcome of this disagreement was a change of care provider at the end of May 2022. At this stage, the decision was made not to share the safeguarding concerns with the new provider's carers. It was stated that this was to avoid the situation of Franklyn's mother feeling judged. The decision-making process in relation to non-disclosure of the safeguarding concerns to an employed carer, in this instance was flawed, as it did not focus upon the need to safeguard Franklyn. Around this time Franklyn's care was transferred to another hospital, which was classed as the mother's local hospital. Although the rationale for this cannot be questioned, it contributed to the situation where Franklyn's mother was needing to develop a trusting relationship with an even greater number of professionals at a time

when she was experiencing high levels of trauma. Franklyn's mother described this transfer of care as "a wrong decision", feeling the hospital where Franklyn`s care was transferred to did not understand his needs.

At the end of May 2022 Franklyn suffered a cardiac arrest which resulted in the admission to hospital where he died five days later.

6. Summary findings and recommendations

The findings are presented below, aligned to key emerging themes.

Theme 1	Trauma-Informed Practice
Theme 2	Family voice including hidden men and the role of the family
Theme 3	Disproportionality, Inequality and Access to Services
Theme 4	Communication
Theme 5	Commissioning of Services

Theme 1

Key Line of Enquiry 1	**Trauma-Informed Practice**

How was this issue relevant to the case?

Franklyn's mother had a history of extensive trauma and loss, which included the experience of fertility difficulties, a history of miscarriages (6-8) and resulting loss, the stress and loss of support from moving house and geographical area (three moves in the antenatal period), a long history of being the subject of domestic abuse which was to a degree that met the threshold for discussion at MARAC, low mood, health challenges including contracting COVID-19 in the antenatal period, antenatal complications including reduced foetal movements, bleeding and gestational diabetes.

Franklyn's mother explained to the author that she had been to the hospital two days before Franklyn's birth and "knew because of the bleeding the placenta was not right". Franklyn's mother experienced a traumatic delivery.

> "My whole life changed within 24 hours".

Franklyn was born with complex needs and a life-limiting diagnosis, resulting in the loss of the experience of parenting a "normal" baby. Alongside this was the trauma of caring for a baby on a daily

basis who was clearly dying. Franklyn's mother gave a clear account of the extensive range of medication Franklyn was prescribed and the day-to-day care he required.

In the early weeks of Franklyn's life his mother also experienced the death of a close family member. Trauma-informed practice is an approach to health and care interventions which is grounded in the understanding that trauma exposure can impact an individual's neurological, biological, psychological and social development. Trauma-informed practice aims to increase practitioners' awareness of how trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff. It aims to improve the accessibility and quality of services by creating culturally sensitive, safe services that people trust and want to use (Office for Health Improvement & Disparities 2022)

It is well recognised that individuals who have experienced trauma are at an elevated risk for substance use disorders, including abuse and dependence; mental health problems (e.g., depression and anxiety symptoms or disorders, impairment in relational/social and other major life areas, other distressing symptoms); and physical disorders and conditions, such as sleep disorders.

Although there is evidence of practitioners recognising elements of trauma, there was no evidence of the application of a holistic trauma-informed practice model as a planned action by the network of professionals. There was evidence that specific professionals responded to mother sensitively and with understanding of her trauma.
The adoption of a trauma informed practice model may have provided professionals with a different understanding of Franklyn's mothers engagement with services and would have supported risk assessment as part of the multiagency work undertaken to safeguard Franklyn and his sibling.
The trauma of experiencing the death of Franklyn will require support longitudinally.

Why is this important?

A history of traumatic experiences, particularly pervasive interpersonal trauma, can erode an individual's capacity for trust in others. Implementing trauma-informed approaches can enable those with a history of trauma to engage safely with the right services at the right time, promoting healing through positive relationships. Critical to this is creating the systems that enable people to come together in compassionate and empathetic encounters. Trauma can impact on a person's ability to form trusting relationships, feel safe within services or to recognise a situation that may be causing them harm.

Implementing trauma-informed services can improve assessment and planning processes, while decreasing the risk of re-traumatization. The adoption of a trauma-informed approach will enhance communication between the client and professional, thus decreasing risks associated with misunderstanding the client's reactions and presenting problems or underestimating the need for appropriate referrals for evaluation or trauma-specific treatment.

In the case of Franklyn's mother, it appears that she was often misunderstood. There were times that she appeared angry, found trust difficult, was assessed as not understanding information relating to the care and prognosis of Franklyn, and there was evidence of documentation of missed

appointments. A holistic, trauma-informed lens would support practitioners in developing services that support positive partnership and engagement (Sweeney et al 2018).

If children are to be safeguarded it is important that a holistic approach is taken to understanding and responding to trauma. It would be expected that parents of children born with complex needs and a limited life expectancy would feel grief and depression on hearing of a child's prognosis and the loss of the type of life that they had imagined living and the achievements they wished for their children. It may take some time to come to terms with the diagnosis and understand the quality of their child's life.

In the lead up to and the period following the death of Franklyn, professionals recognised the need to provide services to support Franklyn's mother and sibling. The bereavement offer to Franklyn's family included:

- The services of a specialist bereavement nurse who acted as a key worker.
- Services from the hospice who also assigned a key worker, provided services of a creative therapist for Franklyn's sibling, and provided the services of a family support worker to offer services based on the bereavement pathway which continues for three years post-bereavement.
- Hospital bereavement services including services of a bereavement and clinical psychologist.

In addition, memory work was undertaken and as part of the Merton offer, an appropriate consultant neonatologist or paediatrician is identified after every child's death to support the family. This is usually someone already familiar with the family, particularly in this instance where the child had a life-limiting condition and was well known to the team. There is also the option of signposting to expert bereavement services if required.

The bereavement service offer is comprehensive; however, it focuses solely upon bereavement resulting from a death rather than the wider experience of multiple trauma and losses as was the experience of Franklyn's mother. The service offered involved her needing to engage with several professionals from various organisations. This is of relevance as Franklyn's mother had expressed to one professional how she "found the involvement of so many professionals overwhelming" and in conversation with the author, Franklyn's mother expressed the feeling of "bombardment" and described how "professionals may class it as support, but it was a bit too much". There were several entries in records where Franklyn's mother did not engage with the services offered. Additionally, in the plan, developed at the review conference for Franklyn's sibling, concerns continued to be expressed regarding the need for ongoing bereavement support. It is important that consideration is given as to how professional systems help parents such as Franklyn's, where there is such an extensive level of trauma and loss and so many professionals with whom engagement is required.

Bereavement sector policies mandate equitability and fair access, yet there is evidence that certain populations, including black and other minority groups, are less likely to proactively seek out and access professional care and support – even when needed and wanted – and are more likely to feel uncomfortable asking for help (Selman et al 2022). Prioritising equity means identifying, assessing and meeting unmet needs in the bereaved population, adapting services and outreach to ensure inclusivity

and working in partnership to ensure the services meet the needs of individuals such as Franklyn's family.

Although there are child death partnerships across the country and bereavement services from a range of organisations, the experience of grief and loss for families such as the family of Franklyn goes beyond that in response to the death. It is important that any bereavement and loss service provides a flexible service.

Evidence of good practice

There were several examples of good practice.

- The hospital discharge coordinator, the health visitor, the social worker and the Merton IDVA showed persistence and creativity in finding ways of working with Franklyn's mother when she appeared angry and reluctant to engage. They tried to build empathic relationships.
- There is evidence of high-quality referrals to services to address current presentations of distress.
- The Merton GP service, despite the very short period since registration, demonstrated a good knowledge of history, wider family support, and ensured follow-up and flexibility when appointments were missed.
- The social worker was pro-active in reaching out to all appropriate services including the hospice to understand what support was available.
- The school had a comprehensive knowledge of the family, built a positive relationship and provided high levels of extended care for Franklyn's sibling.

Recommendation 1. Trauma-informed practice – The adoption of a trauma-informed model of support The Merton Safeguarding Children's Partnership should assure themselves that a Trauma-Informed Model of support, underpinned by a learning and development programme for professionals, is evidenced in case work across all partner agencies in Merton with consistency around definitions and approach.

Recommendation 2. Bereavement and loss – Utilising the family voice. The Merton Safeguarding Children Partnership's partners should gather and analyse feedback from those with lived experience in the ongoing development of bereavement and loss services to ensure a flexible model that is responsive to need.

Theme 2

Key Line of Enquiry 2	**Family voice including hidden men and the role of the family**

How was this issue relevant to this case?

In order to understand the lived experience of Franklyn, hearing the voice of the family is of paramount importance. Franklyn was a child who was preverbal and presented with complex needs. He was part of a large extended family. The records of professionals stated that Franklyn's maternal grandmother lived nearby, and Franklyn's mother had five sisters and one brother. The father(s) of Franklyn and Franklyn's sibling were not known; however, Franklyn's mothers' male partner was involved in the family.

In viewing the available information there is evidence of the voice of the family being sought with family participation in discharge planning meetings and Child Protection conferences.
A family group conference was planned but needed to be postponed as the date was not convenient for the family. Unfortunately, this appears not to have taken place before Franklyn died.

Within Merton, the Effective Support for Families model is used to support the assessment of needs of children, young people and families and promote a consistent approach across agencies. In adopting this approach, the underlying principles are that the model is relationship-based and systemic; having an understanding that individuals are part of a wider context and considering this when working to identify goals and how to achieve them. In applying this model, the principles within the Signs of Safety approach have been adopted (Turnell and Edwards, 1999). This is an approach that aims to work collaboratively and in partnership with families and children, to complete an assessment of risk and needs and to produce action plans for increasing safety and reducing risk and danger. The approach focuses on strengths, resources and networks that the family have (Bunn, 2013, p7). In viewing the Child Protection plan it is apparent that the voice of Franklyn's mother was sought in conferences ahead of professionals, and although the assessment of risk as perceived by Franklyn's mother differed from that as assessed by professionals', it offers the opportunity for further exploration with the family to support reaching as near as possible a shared view of risk and what needs to change to address the risk.

In viewing agency reports there are a number of occasions in one-to-one interactions with professionals where it is recorded that Franklyn's mother felt that she was not being listened to and there are records of her feeling overwhelmed with the demands of the care required by her son.

In conversation with the author Franklyn's mother cited a number of occasions when she felt she was not listened to.

Within safeguarding there is a need continually to build strong relationships with families, adopting a family-focused, compassionate approach which accords parents respect and recognition.

Throughout the period of the review there are ongoing concerns regarding domestic abuse and substance misuse. Some of the concerns are historical and some are new concerns. One of the expressed safeguarding concerns focused on the potential risk posed by Franklyn's mother's partner; however, very little is known about him or Franklyn's mother's current relationship with him. Professionals are not aware of the identity of Franklyn's father, or that of his sibling. Mother's partner was initially in the hospital but was banned due to substance misuse issues on the premises. This had the effect of removing a route for engagement with the partner.

The Child Safeguarding Practice Review Panel undertook a thematic review in 2021 which suggested supervisors and those overseeing frontline practice need to ensure that the assessment and engagement of fathers/significant males is evident within the work of their frontline staff. Child in Need and Child Protection planning should maximise engagement of father/significant men.

In the case of Franklyn this was particularly important as one practitioner reflected:
"Franklyn's mother and her partner had a lot of shared experiences at this time and all the associated emotions".

The practitioner had attempted to ascertain information on Franklyn's mother's partner but without success:

> "Discussions with mother about her relationship with her partner and her feelings about him were difficult and any attempts were quickly shut down by her. Pursuing a line of enquiry was also difficult as I was very much aware of the need to be sensitive to mother's emotions regarding coming to terms with having a child with a complex, life-limiting condition, coping with a recent close family bereavement, coping with having a large team of professionals in her life, as well as grieving for the child and family life she had anticipated and had long term hope for when pregnant"

In the case of Franklyn, the extent to which mother's partner was a strength or a risk was never fully understood. Franklyn's mother expressed to the author "whatever I was going through did not affect my parenting".

Why is this important?

Participatory practice is acknowledged as increasingly important in empowering families in the decision-making process. If children are to be safeguarded, working in partnership with families is essential. Yet parental participation in safeguarding, a complex and multi-dimensional practice, dependent on a range of individual factors including willingness to engage, is varied. Parents can feel 'powerless and helpless' when not involved in decision-making processes.

In the lives of children significant males may play a protective role, or indeed may pose a risk. Assessing the part significant males play in families with children is an essential element of good safeguarding practice.

Evidence of good practice

Following the birth of Franklyn, the benefits of a family group conference (FGC) were recognised and this was planned. Family group conferences are key mechanisms to engage the family. The Family Rights Group (FRG), advocates for FGCs as the best way to involve parents and wider family in decision making.

Recommendation 3. Family-focused communication in assessment practice – Scrutiny of practice
To further embed Merton's Effective Support for Families model, the Merton Safeguarding Children's Partnership should undertake a deep dive to scrutinise assessment practice and planning when services are provided to children with complex needs across education, health and social care.

The scrutiny should evaluate the extent to which assessments effectively consider:

- That the family voice is clearly evident, and that planning is undertaken with families.
- That the voice of the child, even if preverbal and with complex needs, is considered.
- The role/risk significant men/significant others play in the lives of the child.
- The role of the wider family and what "family support" is available.
- The significance of intersectionality - race, ethnicity, trauma and the additional needs for the child and family when a child has complex health needs.
- How the family is supported to understand the complexity of the support offer.
- That any issues of interagency disagreement were resolved collectively.

Theme 3

Key Line of Enquiry 3	**Disproportionality, Inequality and Access to Services**

How was this issue relevant to this case?

Franklyn was a child who is described as Black/Black British/Caribbean. He was a child with complex health needs who lived with a single parent and his brother. As part of this review consideration was given to disproportionality, reflecting the Social GGRRAAACCEEESSS (Burnham, 2013), and whether Franklyn's mother's ethnicity had any impact on how services engaged with the family.

Franklyn's mother is a black woman who was also a single parent, and had the responsibility of caring for a disabled child. Each of these factors alone poses challenges and needs consideration by professionals engaging with a family; however, when working with families with more than one factor, the negative impact experienced increases.

In viewing reports submitted as part of the review there was scant reference to the significance of the family's heritage or of Franklyn's mother being a single parent. Reports show that those working with the family were aware of the possible impact of issues of ethnicity and culture but there is no evidence of this in explicit discussion with Franklyn's mother. There was more focus on the complex needs of Franklyn, which is important and was the reason for the involvement of many professionals who contributed to the provision of the care package, but not the only significant factor.

The panel overseeing this review debated whether professionals responded differently or made decisions differently in response to Franklyn and his family's race and ethnicity. An awareness that mother was feeling judged may have been a factor in some decisions. Staff did respond well to mother. However, the planning does not show a deliberate and open dialogue about the intersectionality of mother and the wider family's experience, and about how that might affect their responses to professionals and professionals' responses to them. By looking at the evidence about mother's experience as the key person responsible for the safety of her child, it again helps us to reflect about how we might gain greater insight in responding to families and lead to better planning with them in the future.

In conversation with Franklyn's mother as part of this review, she reported "feeling judged a lot in terms of the past". Franklyn's mother expressed the view that as a result there was delay in Franklyn being discharged, depriving her of precious time with Franklyn to "make memories".

An intersectional approach is needed to understand the unique challenges faced by families such as Franklyn's. This approach assumes that multiple categories of difference, such as ethnicity, class, gender, or disability, not only independently affect one's lived experience but might also reinforce one another.

As part of the review expert advice was sought from the BME forum and an organisation that supports families where their child lives with a disability. They shared their experience:

> "I have worked with many families, and the experiences expressed have been that there is a lack of knowledge of the black experience for women who have suffered trauma, and a lack of understanding of why from an ethnic minority group they may not be forthcoming due to their fear and due to their prior experiences "

The expert from the BME forum further explained that often there is a lack of trust when interacting with professionals that has passed through generations through socialisation. Building trust and developing communication channels are crucial to overcoming the barriers to empowerment faced by black lone mothers. The trauma discussed in Theme One can be intergenerational.

The NICE quality standard, promoting health and preventing premature mortality among black, Asian, and other minority ethnic groups, is relevant to all age groups and all settings and draws attention to some of the specific areas of inequality for people from black, Asian, and other minority ethnic groups, such as increased health risks, poor access to and experience of services, and worse health outcomes. It aims to support public authorities in considering their equality duty when designing, planning, and delivering services.

In a previous serious case review regarding Family A, which involved a child who had lived in Merton and was undertaken by another Safeguarding Children Partnership, there were two recommendations that align with the case of Franklyn:

- That the Merton Safeguarding Children Partnership should assure themselves that there are reliable systems in place to ensure that whenever a child is diagnosed with a disability, the parents are offered counselling and information support as a routine, and that professionals also explore with them their understanding of and views towards such disability.
- That the Merton Safeguarding Children Partnership considers how to improve assessment practice so that practitioners routinely explore parents' individual cultural background and attitudes to the provision of services.

Why is this important?

Good safeguarding practice acknowledges the complexity of peoples' lives, and the many enablers and barriers they may face in keeping themselves and their children safe and well. Black lone mothers

and their children face well-documented social and economic problems. Lone parenthood is difficult for everyone, and black women face challenges, including documented wider difficulties accessing appropriate services. An understanding of this complexity is part of building empathic relationships with families as part of the shared practice model.

Evidence of good practice

A number of professionals adopted creative approaches in finding ways of working with Franklyn's mother when she appeared reluctant to engage. Examples of approaches taken by practitioners included "taking her to the hospital cafeteria for a chat and a hot drink" as a way of breaking the ice and encouraging open conversation. This resulted in positive engagement with professionals, notwithstanding an imbalance in the respective ethnicities with professionals frequently being white British.

Recommendation 4. Intersectionality – Promoting best practice. The Partnership to take note of issues of bias and how they play out in safeguarding around children with complex needs, as part of their work around intersectionality

Theme 4

Key Line of Enquiry 4	**Communication**

How was this issue relevant to this case?

In undertaking this review, overall, there is evidence of good multiagency working throughout the process which aimed to ensure Franklyn and his sibling were safeguarded. Professionals recognised potential safeguarding concerns and referrals were made appropriately. There is evidence of multiagency and family participation in the Child Protection conferences and discharge planning meetings.

However, there were areas where communication worked less well and where there was some evidence of "tensions" between professionals. This was mainly in relation to the discharge planning for Franklyn. Prior to Franklyn's discharge, the discharge co-ordinator was on leave for a period. The team within the ICB, involved in the plan for discharge, were unaware of this.

The discharge planning of a child such as Franklyn is complex with many interdependencies. In considering all available information for this review there were clear examples of agencies not always understanding the challenges faced by other agencies or the rationale behind certain pathways.

The view was expressed that hospital staff were not listening to the ICB with regards to the difficulty in sourcing an agency and continued with the discharge process, building mother's expectations with regards to going home; this led to a rushed final discharge. Additionally there appeared not to be a clear understanding across the partnership of the challenges faced by those responsible for the provision of appropriate housing.

Through the process of this review agencies have expressed a wish to better understand each other's service criteria, the challenges, and constraints. It is positive that Merton agencies are planning to hold a partnership event to address this. Disagreement within Child Protection processes can be evidence of a healthy dialogue focused on children's safety. However, it was recognised that there was a mutual need in the network to understand each other more.

More substantial and regular communication is required when planning such a complex discharge. Communication is of particular relevance for this case as Franklyn's family moved between three separate geographical locations within the space of a few months, and there was a need to ensure that relevant information was shared promptly between areas and services, as Franklyn's mother was pregnant and there were concerns related to domestic abuse.

Despite the moves, information relating to the mother's pregnancy and history of domestic abuse were communicated between areas. This enabled continuity of care.

In discussion with Franklyn's mother, she felt the move to Merton, whilst she was pregnant and caring for a school-aged child, was reasonably smooth, although understandably it was "a confusing time". Mother helped the communication by informing Merton social care she was living in the borough and by providing the history of recent agency involvement.

There were areas of communication that worked less well, and reference has already been made to the decision not to share with the professional carers information regarding the safeguarding concerns. The agency recognise that this was not good practice and changes have already been made.

There was also different understanding of the relevance of parallel planning. This had an impact upon the discharge planning for Franklyn. Staff within the hospital had understood that there was a plan for Franklyn to be settled in a placement outside the family home, which resulted in delay in training family members in aspects of the care that Franklyn would need at home. Records indicate that the Local Authority were discussing the case with their legal department, but there was no indication that there was a plan for a placement outside the home.

Communication with the mother was also critical. It has already been discussed above how mothers understanding could have been hindered by trauma and a lack of trust. This is evidence that professionals worked hard to communicate with mother, but as there was not clarity across agencies this was compromised at discharge. Mother also did not accept the need to transfer care to a second hospital. Communication was also challenging for mother due the wide variety of agencies in contact with her or involved in decisions about the family.

Why is this important?

Information sharing is an area of learning that is repeatedly raised in Local Child Safeguarding Practice Reviews. Communication and appropriate information sharing are an essential element in ensuring children are safeguarded and service delivery is seamless.

Evidence of good practice

There were several areas of good practice highlighted in this case:

- When the mother of Franklyn transferred antenatal care from one hospital to another, the receiving hospital telephoned the transferring hospital to gain an understanding of any safeguarding concerns.
- Written referrals to access support for the family were of a high quality.
- The family participated in Child Protection conferences and discharge planning meetings enabling them to hear the same information as professionals.

Recommendation - see recommendation 3.

Theme 5

Key Line of Enquiry 5	**Commissioning of Services**

How was this issue relevant to this case?

Franklyn had complex health needs, with a life-limiting diagnosis. The National Framework for Children and Young People's Continuing Care was used in supporting decision making around the package of care. This is an NHSE framework and cannot be changed locally. The package commissioned covered Franklyn's needs. However, the needs of Franklyn's sibling would not be addressed through this framework and therefore relies on a seamless approach between health commissioners and the Local Authority. The package of care for Franklyn was funded partly by the Integrated Care Board and partly by the Local Authority but using the same provider to provide both elements of care. As has been discussed, there was a time when the agency felt trained nurses should be providing the care because of the needs of Franklyn, but this view was not shared by all professionals.

Commissioners faced challenges in commissioning the package of care and coordinating the equipment required to provide care at home. In addition there was evidence of differing professional views around the appropriate timing of discharge. The differences of opinion centred on an attempt to balance his complex needs on the one hand and the need for his family to spend time with him in their home environment, given his prognosis. These challenges resulted in some delay in discharging Franklyn from hospital. This had significant impact on the family of Franklyn as they were aware that Franklyn had a limited life expectancy. This was a time of great frustration for Franklyn's mother who felt "it was out of order that I was unable to take my son home when we knew his life was limited". She referred to attending several meetings about the care package and felt that staff underestimated her ability to care for Franklyn at home as "they didn't understand how quick I had learnt about his needs and was his advocate".

In discussion within an expert from Kids First they spoke about the need to:

> "Create moments for these families".

They went on to say that in working with families, they recognise that we cannot take away the tragedy but "creating moments will enable memories that will always be cherished".

Although the National Framework is a nationally adopted approach to commissioning care, in the case of Franklyn and his family, the care package commissioned did not allow the flexibility needed by a single parent of a child with a disability who has responsibility for another child. The tool currently used within Merton ICB, to calculate the hours provided, does allow for an element of additional support for single parent families but is currently being reviewed by the central Integrated Care System All Age Continuing Care team with the aim of agreeing a consistent approach across South-West London.

Why is this important?

The lives of disabled children with complex needs and life-limiting disabilities and that of their family can be improved by agencies and services that:

- are joined-up.
- are tailored to the needs of the individual child and the individual family circumstances.
- involve the voice of the family in decisions about their care.
- incorporate support for families and carers.
- embed person-centred values into local commissioning approaches so that services are designed with service demand, people's aspirations and needs, and diversity and inclusion in mind from the outset.

Recommendation 5. Commissioning – Achieving a seamless approach.

The newly formed Integrated Care System (ICB and LA) to provide assurance to the Merton Safeguarding Children Partnership that commissioning arrangements to support the needs of children with complex health care needs are integrated and joined up with clear pathways. This will seek to ensure that the unique circumstances of families caring for the child are taken into account and include the Family Centred Approach.

Key constituents should include:

- Effective health and multi-agency agreements and funding arrangements.
- Needs-led appropriate and effective care package that acknowledges additional support that may be needed according to circumstances.
- Consideration as to how the voice of the child is enabled and their needs remain the central focus
- Reflecting the principles that underpin the Nice Quality Standards 1,2,5 and 6 of promoting health and preventing premature mortality in black, Asian, and other minority ethnic groups (NICE 2018)
- Coordinated and accessible services following hospital discharge with a clear pathway for hospital/community interface.
- To scope the opportunities for funding and provision of an identified lead support role for families that reflects an independent advocacy approach. This role would act as a single point of contact and would provide support in the navigation of complex systems to help families of children born life-limited.

7. Summary of recommendations

This review builds upon the learning that has been identified and is being taken forward by the partnership following the rapid review and Joint Agency Response. In contributing to this review, individual agencies have identified single agency recommendations that will be progressed within their agency. It is recommended that Merton Safeguarding Children Partnership seek assurance that those recommendations have been progressed.
The recommendations arising from this review are detailed below, with details of the themes with which they align.

Number	Recommendation	Themes that recommendation emanate from
1	**Recommendation 1. Trauma-informed practice – The adoption of a trauma-informed model of support** The Merton Safeguarding Children's Partnership should assure themselves that a Trauma-Informed Model of support, underpinned by a learning and development programme for professionals, is evidenced in case work across all partner agencies in Merton with consistency around definitions and approach.	**Trauma-informed practice** **Family voice**
2	**Recommendation 2. Bereavement and loss – Utilising the family voice.** The Merton Safeguarding Children's Partnership partners should gather and analyse feedback from those with lived experience in the ongoing development of bereavement and loss services to ensure a flexible model that is responsive to need.	**Trauma-informed practice** **Family voice** **Disproportionality, Inequality and Access to Services** **Commissioning of services**
3	**Recommendation 3. Family focused communication in assessment practice – Scrutiny of practice** To further embed Merton's effective support for family's model, the Merton Safeguarding Children's Partnership should undertake a deep dive to scrutinise assessment practice and planning when services are provided to children with complex needs across education, health and social care. The scrutiny should evaluate the extent to which assessments effectively consider: - That the family voice is clearly evident, and that planning is undertaken with families. - That the voice of the child, even if preverbal and with complex needs is considered. - The role/risk significant men/significant others play in the lives of the child	**Communication** **Family voice** **Trauma-informed practice**

<table>
<tr><th>Number</th><th>Recommendation</th><th>Themes that recommendation emanate from</th></tr>
<tr><td></td><td>- The role of the wider family and what “family support” is available
- The significance of intersectionality - race, ethnicity, trauma and the additional needs for the child and family when a child has complex health needs
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- That any issues of interagency disagreement were resolved collectively.</td><td></td></tr>
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The newly formed Integrated Care System (ICB and LA) to provide assurance to Merton Safeguarding Children Partnership that commissioning arrangements to support the needs of children with complex health care needs are integrated and joined up with clear pathways. This will seek to ensure that the unique circumstances of families caring for the child are taken account and include the Family Centred Approach.
Key constituents should include:
- Effective health and multi-agency agreements and funding arrangements.
- Needs-led appropriate and effective care package that acknowledges additional support that may be needed according to circumstances.
- Reflecting the principles that underpin the Nice Quality Standards 1, 2, 5 and 6 of Promoting health and preventing premature mortality in black, Asian, and other minority ethnic groups (NICE 2018)
- Coordinated and accessible services following hospital discharge with a clear pathway for hospital/community interface
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Trauma-informed practice

Family voice

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Number	Recommendation	Themes that recommendation emanate from
	families that reflects an independent advocacy approach. This role would act as a single point of contact and would provide support in the navigation of complex systems to help families of children born life limited.	

8. Closing Statement

In undertaking this review, it is important to acknowledge the impact that the death of Franklyn had on the family and professionals whose lives he touched. All professionals involved in this review held open, honest, and difficult conversations. This review has highlighted examples of excellent practice across the Merton partnership as well as areas for development. The hard work and willingness to improve practice in Merton is acknowledged. We are very grateful to Franklyn's mother for sharing her experience so openly. Whilst this review was in progress, professionals had already started making changes. The actions from this review are agreed by all partners and will be carried out by representatives from the Merton Safeguarding Children Partnership.

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9. Glossary

DYSTONIA
Dystonia is a medical term for a range of neurological disorders which cause muscle spasms and contractions.
FOUR-LIMB CEREBRAL PALSY
A physical disability caused by damage to the brain during pregnancy, at or shortly after birth. In the four-limb form it causes muscle spasm and severely affects movement, muscle tone and control.
GASTROESOPHAGEAL REFLUX
This is a condition where stomach acid repeatedly flows back from the stomach into the oesophagus.
HYPOXIC ISCHAEMIC BRAIN INJURY
This occurs when there is a lack of blood flow to the brain; it occurs during labour, at birth or shortly afterwards.
IDVA
A specialist who works with a victim of domestic abuse to develop a trusting relationship and provide advice and support to become safe and rebuild their life.
MARAC
A multi-agency meeting that is held to discuss the most high-risk cases of domestic abuse to share information and to safety plan to protect those experiencing the abuse.
PLACENTA ABRUPTION
This occurs when the placenta partially or completely separates from the inner wall of the uterus before delivery.
TOTAL BODY HYPOTHERMIA
This is an induced cooling process used to treat neonates with hypoxic ischaemic brain injury.