



Serious Case Review

CHILD SAM

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1.1. The Circumstances that led to Undertaking this Review

- 1.1.1. Child Sam was brought to a Minor Injury Unit (MIU) by his (step) aunt and (step) grandmother. Whilst in the unit, Sam had a respiratory arrest and was transferred by ambulance to the resuscitation area of the Accident and Emergency (A&E) Department at the local District General Hospital where he underwent full resuscitative measures. His clinical presentation suggested raised intracranial pressure secondary to trauma and this was confirmed on CT¹ scan, which showed subdural haemorrhages. His injuries were due to non-accidental/ inflicted injury. Both parents were reported to be drunk in A&E.
- 1.1.2. Child Sam was transferred to Bristol Children's Hospital Intensive Care Unit under the neurosurgical team. Fluid was drained from Sam's brain and the neurological team confirmed that extensive brain damage had ensued.
- 1.1.3. Sam is blind with reduced hearing, he is unable to feed and he cannot protect his airway. His brain damage is severe and irreversible. There is no chance of a normal development and very little chance of any development at all. Sam was six months old at the time of the injury.
- 1.1.4. The Somerset Safeguarding Children Board's (SSCB) Learning and Improvement subgroup recommended to the Chair of SSCB that the case had met the criteria for a Serious Case Review (SCR) as identified in Working Together to Safeguard Children 2015², in that there was information that:
 - (a) *abuse or neglect of a child is known or suspected*The Chair of the Board accepted the recommendation and commissioned the Review.
- 1.1.5. The stepfather was found guilty of Grievous Bodily Harm (GBH) and received a custodial sentence.
- 1.1.6. Sam is now living with his mother and maternal grandmother who are currently undergoing a parenting assessment to determine whether they can provide long term care for Sam.

¹ A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body.

² Working Together. HM Govt 2015

1.2. Family Composition

1.2.1. The family members relevant to this review will be referred to as follows:

Family member	Anonymisation	Age at time of Sam's injury	Ethnicity
SUBJECT	Sam	6 months	White British
Mother of Sam	Mother	22	White British
Father of Sam	Father	23	White British
Stepfather of Sam	Stepfather	29	White British

1.2.2. **Family involvement.** The involvement of key family members in a Review can provide particularly helpful insights into the experience of receiving or seeking services. Letters were sent to the mother, father and stepfather informing them about the process and inviting them to contribute. Following completion of the criminal trial the independent author met with Sam's mother; her views on how services could have been improved are incorporated in the relevant sections of the report. The mother disclosed financial dependency on her partner; this made it very difficult for her to leave him. She felt unable to return to her own mother as she had not been supportive of the relationship and she also lived in close proximity to the stepfather's extended family. The mother talked about how isolated she felt having moved into the area from a neighbouring county and had no close friends locally. The mother told me that she felt the stepfather's extended family were unsupportive and critical of her, and at times felt scared of them. Sam's mother also thought that it would be helpful to have telephone numbers for agencies (in the Parent Held Child Health Record) that parents could contact for advice and support confidentially.

1.3. Brief Summary of the Case

1.3.1. The relationship between the mother and father of Sam had broken down early into the pregnancy. The mother expressed concern that her ex-partner was allegedly stalking her and that she was clear that he would have to apply through the court for access to his child. Following the break up of this relationship she commenced a relationship with the stepfather and they lived together in the house that she shared with her mother and her mother's partner. Shortly after the birth of Sam the family (Sam's mother, Stepfather and Sam) were housed in a local market town (the town is ranked amongst the 20% most deprived areas in England)³ about six miles away from the village where the stepfather and his extended family lived.

1.3.2. The mother had expressed 'low mood' during the antenatal period, which continued in the postnatal period. The professionals working with the family following the birth of Sam were unaware that Sam's mother's partner was not the biological father. The stepfather was working away from the family home for two weeks at a time and the mother felt lonely and isolated. The stepfather suffered a

³ Indices of Deprivation. DCLG, 2015.

significant and traumatic bereavement. He subsequently lost his job and was reported to be out drinking with his friends, rather than supporting and helping the mother with the care of Sam. Although the mother engaged with professionals, sought appropriate interventions for Sam, she did not always act on the advice given.

- 1.3.3. Three weeks before the non-accidental injury, Sam was admitted to Musgrove Park Hospital (MPH) with a five-day history of vomiting, and a 'floppy' episode. Sam was admitted overnight as the history of vomiting and the absence of diarrhoea was 'unusual' and the mother reported that Sam had been irritable and had 'cried all night'. Sam was discharged the following day; there had been no further vomiting overnight. Three weeks later the non-accidental injury occurred.

2.1. Methodology

For details about the review process and methodology; see Appendix 1.

3. How Professionals Understood the Case at the Time

- 3.1. The following section is a summary reconstructing how professionals understood the experiences of the mother, stepfather and Sam and their situation at the time.
- 3.2. The mother had separated from the biological father during the early stages of the pregnancy and expressed concern that he had mental health issues, misused drugs and was allegedly 'stalking her'. The midwife referred the case to First Response Team⁴. However, as the mother was no longer in a relationship with the father and was living with her mother at the time and was attending her antenatal appointments Children's Social Care (CSC) took no further action; no other risks to the unborn child or mother were identified. A Midwifery Communication form⁵ was completed and shared with the General Practitioner (GP) and the Health Visitor (HV).
- 3.3. HV1 visited the mother in early March at the home she jointly owned with her mother, they had bought the property with money left to them by her grandmother. The mother was very close to her grandmother who brought her up. The mother informed HV1 that she was now in a relationship with the stepfather and that he wanted to bring the child up as his own, this was seen as a positive factor. He had a large extended family that lived locally but no further information was gained.
- 3.4. A Consultant Obstetrician who saw the mother at approximately 36 weeks discussed the previous domestic abuse and the current state of the relationship, and it was recorded that the ex-partner was now not in contact, and that her new partner was supportive. A week later the mother reported that she had had a 'fall / blackout' and had bruised her arm; she also disclosed that there were family

⁴ First Response Team- first contact for Children's Social Care

⁵ A risk assessment form

arguments. This was followed up at the 38-week appointment when it was reported that the mother was tearful, 'doesn't feel like speaking to anyone' and is a 'bit snappy with her partner'. She expressed that she felt like hiding away. The midwife did not explore this further at these visits.

- 3.5. Sam was born by an emergency Caesarean Section. Mother and Sam were discharged home on day one post section at the mother's request, as she was unable to sleep. Sam was bottle fed. On day five post-section the Mother attended the A&E department at MPH complaining of chest pain, she was discharged later that evening with a diagnosis of muscle pain.
- 3.6. HV2 undertook the Primary Birth Assessment at the mother's home, it was noted that Sam was fit and well and that he was on the 50th centile⁶ for weight. The family (mother, stepfather and Sam) was hoping to move house shortly. The family were assessed as meeting Universal Plus Service. In early June the mother was seen by a locum Nurse Practitioner (NP) at the GP surgery complaining of elbow pain, however it was noted that she was tearful at times, and told the NP that she had moved from a neighbouring county the previous year, lived with her new boyfriend and had no local friendships. The NP arranged for the mother to be reviewed the same day by a GP, as she was concerned about post-natal depression but did not inform the health visitor.
- 3.7. HV3 visited the family at their new home for the six-week assessment; and the family are assessed as meeting the Universal Plus service. The GP had made a referral to the Paediatrician due to Sam's abnormal head shape (brachycephaly)⁷ and a small iris coloboma (a defect in the coloured part of the eye). It was noted that Sam's weight was on the 9th centile; HV3 asked the mother to bring Sam to the local Child Health Clinic (CHC) to monitor his weight. Sam's weight had dropped from the 50th centile to the 9th centile. The mother stated that she had been suffering from a low mood and had seen the GP about this; she was not on any medication. The HV asked a Whooley⁸ question which was answered positively. A positive screen requires a standard clinical assessment to take place; it does not establish the diagnosis of depression, just a possible one. HV3 offered extra support visits these were declined.
- 3.8. At the end of July mother took Sam to the CHC where she was seen by HV4. The mother told HV4 that she had been tearful, and that this was not helped as the stepfather was working away from home for two weeks at a time and he didn't always contact her, as his work was very 'stressful'. Mother would like to go back to college but the stepfather was not supportive about this and his family was also being 'difficult' about it. It is recorded that Sam had gained weight but no record of weight or centile was noted in the records. At this time (July 2015) weights were recorded in the Parent Held Child Health Record (PHCHR) and on a 'Clinic Record Sheet' (CRS) which would be reviewed by the named Health Visitor (if not present at the Clinic). The CRS were kept for a year and then destroyed so this

⁶ UK – WHO growth charts 2016

⁷“ A common benign condition where the back of the head appears flattened, and the head widened, usually caused by in utero positioning and sleep pattern, and usually correctable by positioning in infancy.”

⁸ Depression Screening Tool

particular weight was not available without the recall of the PHCHR. The practice of recording growth measurements has now changed as the RiO electronic record includes centile charts that plot all measurements that are uploaded on to RiO. Clinic measurements are uploaded in this way.

- 3.9. HV3 visited the family in the middle of August for the 12 week core contact. HV3 saw mother and Sam in the sitting room whilst the stepfather remained in the kitchen for the duration of the visit. Mother informed HV3 that the stepfather's brother had died last week and that he was currently 'off work' and that she was supporting him. HV3 did go into the kitchen to talk to the stepfather about his bereavement and to offer any support that he might need. HV3 delayed using the screening tool for mother's emotional health and wellbeing in view of the circumstances and arranged to visit again in two weeks to assess and check Sam's measurements; Sam's weight was noted to be on the 9th centile and his height and head circumference on the 91st. HV3 planned to review Child Sam in two weeks time due to the differences between these measurements and on different centiles. The mother cancelled the planned visit with HV3 by text as the stepfather's brother's funeral was planned to take place the following day. HV3 responded and asked the mother to get in touch following the funeral.
- 3.10. On the 15.09.15 the mother rang the GP surgery as Sam was unwell; the GP arranged a home visit for later the same day. The GP made a diagnosis of a viral infection, and arranged for Sam to be reviewed the next day at the surgery. The GP was struck by how sparse the house was and felt that the family were isolated, he encouraged them to spend time back with their respective families. Sam attended the appointment with his mother, he seemed to be better, and after a further examination it was agreed that no further action was needed unless his condition changed or mother was concerned. This information was not shared with the health visitors.
- 3.11. HV3 received a text message from mother on the 16.10.15, "*is there anywhere I can go to speak to someone today?*" HV3 spoke with mother who disclosed that she felt low, tearful and would often sit and stare into space. She reported that her partner (stepfather of Sam) was trying to support her but he was on anti depressants following the death of his brother. HV3 advised Mother to make an urgent appointment with her GP and that this information would be shared with the new HV.
- 3.12. HV5 contacted mother on the 19.10.15 and mother told the HV that she was feeling better; she had seen her GP and had commenced anti depressants. Three days later HV5 made her first home visit and discussed a number of issues:
- Sam's health and recent visit to the Paediatrician concerning his head shape and that the mother was anxious about some outstanding tests,
 - the emotional impact of the death of her partner's brother,
 - bereavement issues in her own family and a difficult relationship with her own mother
 - the mother had found the birth of Sam very traumatic and felt it was due to the shape of his head.

- the mother told HV5 that she had more energy since starting the anti depressants and was constantly cleaning the house.

The mother also spoke about her relationship with her partner and that the GP had recommended Talking Therapies⁹ for them both regarding the issues they are facing together and individually. HV5 provided information about the Early Help getset service¹⁰; HV5 felt it would help support mother to get out and about and access some relevant groups with Sam. HV5 also contacted MPH to chase up the outstanding test results. At this point HV5 was starting to develop a better understanding of the family situation. It would have been helpful at this point to make contact with General Practice to share information.

- 3.13. On the 26.10.15, Sam was seen by a GP as he had been crying and vomiting. Sam was examined and nothing of concern was found, his mother was given safety netting advice¹¹ and to persist with offering him fluids. The following day the mother contacted the health visiting service and told them that Sam had been vomiting all night and had passed hard stools, which was unusual for him. The mother was advised to stop giving solids until the vomiting had settled and to try a ready-made milk formula to counteract the hard stools. Later the same day a family member rang 111¹² for advice as Sam was still vomiting; they were advised that he should be seen by a GP within two hours but this did not happen. The next day (28.10.15) Sam was brought to the surgery for a 'same day' appointment and was seen by the nurse practitioner, as he was still unwell. His mother reported that he had been 'floppy' that morning, but cried when she picked him up. There was nothing particularly abnormal on examination, but the nurse practitioner was concerned that he was still unwell, and arranged to review him that afternoon. She asked his mother to catch a urine sample. On review in the afternoon Sam seemed more unwell, (his heart rate and respiratory rate had gone up) and his urinalysis was abnormal. The nurse practitioner spoke to the duty Paediatrician at Musgrove Park Hospital who advised her to send the baby to the hospital. This information was not shared with the health visitor or the practice.
- 3.14. The admitting nurse on the Children's Unit had measured and documented Sam's weight, length and head circumference but these had not been plotted on a growth chart. Sam was initially seen and examined by a junior doctor; who gave a provisional diagnosis of gastroenteritis. It was noted that his Mum had postnatal depression and that her partner was also depressed following the death of his brother. The Consultant Paediatrician however felt that gastroenteritis was unlikely given the history; and although Sam appeared well on examination, felt it prudent to admit him overnight and plan further investigations if he did not settle. Sam had no further vomits overnight and was discharged by the ward registrar the following day; the discharge summary said he had a viral infection and had had a 'floppy' episode.

⁹ Talking therapies involve talking to someone who is trained to help you deal with your negative feelings. They can help anyone who is experiencing distress.

¹⁰ Early help and support for children, young people and their families in Somerset, June 2014

¹¹ Introduced to General Practice by Roger Neighbour – it can help to ensure that a patient with an unresolved or worsening symptoms knows when and how to access further advice.

¹² NHS emergency and urgent care service number.

- 3.15. HV5 visited Sam and his mother at home on the 5.11.15. At this visit the mother disclosed that her partner had been assaulted the previous Saturday night at a party in a friend's pub. The mother also told HV5 that she had been subjected to harassment by her partner's family using constant negative text messages and was contemplating ending her relationship. HV5 followed up the alleged assault incident with the Safeguarding Team and the Police confirmed that he had been the victim of an assault but that there had been no safeguarding concerns in relation to Sam.
- 3.16. The mother was seen by the nurse practitioner on the 13.11.15, at this appointment the mother talked about her relationship and that there was conflict between them, she reported that her partner was drinking more and on one occasion when he was drunk she had called the police. This information is documented in the records but is not shared with the health visitor or the GP. HV5 visited Sam and his mother at their home on the 16.11.15 and was told that the mother had just had an argument over the phone with her partner and had told him that she was leaving. The mother explained that he had lost his job and although he was now living at home full time he did not stay with her but went out with friends during the day. The mother talked about feeling lonely and isolated and again HV5 encouraged mother to consider attending local groups and refer herself to Talking Therapies. Sam's weight was now on the 2nd centile and HV5 observed his mother leaving him propped on a chair on two separate occasions over the course of the visit, even after she had been advised not to leave him there.
- 3.17. The following day Sam attended the Minor Injury Unit where he suffered a respiratory arrest, he was transferred to MPH and then to Bristol Children's Hospital where it was confirmed that he had sustained extensive brain damage as a result of non accidental head injuries.

4. Appraisal of Practice and Analysis

4.1. Introduction

This section of the Review assesses the quality of the multi-agency practice at those key points, which were considered to provide the most significant learning. In doing so it takes into account both the contemporary required standards and also the information that was known, or could have been known at the time of the events. Where there is information about why practice may not have met the required standards these are explained. By understanding **why** things happened in the way that they did, rather than simply **what** happened; the Review is seeking to achieve a greater depth of learning about safeguarding systems within Somerset and beyond the individual case. Where learning in relation to individual agencies' practice has been identified within the agency learning summaries it is not repeated here. The recommendations for individual agencies, which were produced at the outset of this Review, are included in Appendix 4.

- 4.1.1. This case involved the non-accidental injury of Sam at the hands of his stepfather. At the time of the incident the family were in receipt of the universal plus health visiting service and accessed the GP as required. During Sam's short life the

number of risk factors within the family increased dramatically, unfortunately the professionals working with the family either failed to recognise the significance of the risks or analyse the potential impact that these risks might have on the parents' ability to care for Sam.

- 4.1.2. The family received short interventions from a range of health professionals but there was little evidence of information sharing between professionals or a joined up plan.
- 4.1.3. Sam was admitted to hospital three weeks before the traumatic injury to his head with a history of vomiting for five days and a floppy episode. Although non-accidental injury had been considered as a potential cause of Sam's condition prior to examining him, when he was reviewed his presentation was a bright happy baby who was clinically well. As a precaution the consultant felt it was 'prudent' to admit Sam overnight for observation and review in the morning, at which point he was discharged.
- 4.1.4. The author is of the view that there was no specific evidence that Sam would experience serious physical harm. However, agrees that there are areas of practice that could have been improved and there are lessons to be learnt that will further strengthen the safeguarding systems in Somerset.

4.2. Whether pre-birth planning guidance was used or could have been implemented to safeguard the unborn child

- 4.2.1. SSCB Multi-agency Pre-birth Protocol to Safeguard Unborn Babies¹³; the purpose of this guidance is to ensure that a clear system is in place to respond to concerns for the welfare of an unborn baby and to maintain clear and regular communication within and between professionals and partner agencies. In order to use this guidance it is reliant on professionals working within the multi-agency safeguarding system to adequately identify risks and take the necessary action. The guidance that was available at the time of the period under review, was generic and not based in local procedures: and was accessed through the Southwest Child Protection Procedures (SWCPP) website. One of the recommendations/actions of a previous SCR was to review this guidance. In October 2015 a small task and finish group was set up to review the then online guidance available to staff. The SSCB re-commissioned the SWCPP online guidance in February 2016 at which time the previous pre birth guidance which had been reviewed was completely removed from the site, with very minimal pre birth guidance to replace it. The SSCB and the Clinical Commissioning Group (CCG) picked this up and an immediate draft pre birth protocol based upon regional practice was constructed and uploaded in January 2016.¹⁴
- 4.2.2. A good assessment, including family history and identification of risk factors, is fundamental to ensuring that a strong and appropriate plan for the level of intervention is put in place. The mother was 21 years old when pregnant; she had

¹³http://www.proceduresonline.com/swcpp/somerset/p_prebirth_sg_unborn.html?zoom_highlight=unborn+baby+protocol

¹⁴ http://www.proceduresonline.com/swcpp/somerset/files/prebirth_pr_sg-unborn.pdf

ended a relationship with the biological father because of mental health, substance misuse and domestic abuse, and had alleged that he was stalking her. She lived with her own mother with whom she did not have a particularly strong relationship having been brought up by her maternal grandmother, who died when she was 14 years old. The mother also expressed 'low mood' during her pregnancy and didn't have any close friendships as she had moved back into the area in the last year. When the mother disclosed that she had formed a new relationship there was an opportunity to assess her new partner to determine whether he presented any risks or whether he was supportive and provided stability. Little additional information was obtained by HV1 about the mother's new partner; HV1 did check on the Trust IT system (RIO) to see if he was known to any of the services provided by Somerset Partnership; no information was available. It would appear that the professionals were concentrating on the 'here and now' rather than considering the history and risk factors that were known. The task of professionals is to remain in a position of *respectful uncertainty* and *display healthy skepticism* which in practice means checking the validity of information provided by parents/adults by cross referencing and triangulating with other sources and other agencies.

- 4.2.3. The midwife made an appropriate referral to Children's Social Care, but the case did not meet the threshold for CSC intervention as at the time the mother was no longer with the father of her unborn child and it was judged that there were no additional risks identified. The midwife also completed a communication form (according to local policy) based on the identified risks and this was shared with the GP and HV1. Given the information shared with CSC at the time this was a reasonable decision.
- 4.2.4. The midwife had asked the mother the Domestic Abuse question at the booking appointment; there was a positive response¹⁵, however it was noted that she was no longer in this abusive relationship. When the mother was seen for her Consultant Obstetric appointment reference was made to the previous abuse and that she was in a new relationship and that he was supportive. It is well known that women (and men) who have been in one abusive relationship are at an increased risk of further abusive relationships. At the next routine midwifery appointment the mother reported that she had had a 'fall/blackout' and had bruised her arm, this was accepted at face value and no further questioning or action taken; this was an omission.
- 4.2.5. After the antenatal contact HV1 assessed that the mother required a Universal Health Visiting service; this is the lowest level of intervention from the health visiting service. This assessment was made despite the fact that the mother disclosed that she was now in a new relationship, which had started when she was over five months pregnant. The mother gave the name of her new partner; there appeared to be little surprise about this relationship and a general acceptance that this was 'not unusual for the area' possibly suggesting staff have a fixed view and have become desensitized.¹⁶ During the conversation with HV1 she was very clear that at the time she had no concerns about the mother and did

¹⁵ Mother disclosed that she had experienced threatening behaviour

¹⁶ Make someone less likely to feel shock, or distress as it is viewed as 'normal'

not assess her as vulnerable, and was more concerned in ensuring that confidentiality was maintained as she was also the health visitor for her new partner's sister.

- 4.2.6. Risk factors are cumulative – the presence of more than one increases the likelihood that the problems experienced and the impact on the (unborn) child and parent will be more serious. What is difficult to determine is whether the professionals working with this family were identifying the risks or understanding the significance of them or recording the information given with little if any analysis being carried out. Research evidence from SCRs (Brandon et al¹⁷) suggests that history is an important part of assessing current and future parenting capacity. A safe child protection system needs to deal proficiently with risk, probability and impact; it is not enough to respond reactively after an incident of significant harm has been caused to a child.
- 4.2.7. Clearly the professionals involved did not consider referring to the Pre-birth Protocol to Safeguard Unborn Babies; had they done so there might have been the opportunity for professionals working with the mother to share information and consider the larger picture. Midwives and Health Visitors and GP's have a unique role during the antenatal period and are critical in identifying and supporting vulnerable mothers; in this case the mother's vulnerability was not identified, nor was her ability to protect her child explored.
- 4.2.8. Somerset is not alone in the low number of pre-birth assessments completed¹⁸; it is therefore imperative that staff are further encouraged to work in partnership and share important information to ensure that intervention is appropriate to the needs and risks identified for the unborn child. The learning from this experience is that staff need to be more pro-active in the use of the Somerset pre-birth guidance to better protect unborn babies.
- 4.2.9. Practitioners must balance their safeguarding duties with respect for confidentiality and for an individual's autonomy. Practitioners depend on what individuals choose to disclose and this is shaped by the awareness, perception, and candour of the individual. This may be a particular issue for vulnerable mother's who may be unaware of a partner's background, deny its significance, or be unwilling or feel too scared to share information with a professional.

Recommendation 1: SSCB needs to be assured that all partner agencies have embedded Multi-agency Pre-birth Protocol to Safeguard Unborn Babies in their practice.

4.3. Assessment of vulnerability factors and if protective factors were identified.

- 4.3.1. The midwife correctly identified concerns about the biological father and made a referral to CSC however as the mother was no longer in a relationship with him the case was judged not to meet the threshold for intervention. At the time the

¹⁷ Brandon et al, 2008

¹⁸ The number of completed assessments between Jan 2015 –Dec 2015 was 4086 of which 156 were on unborn babies (3.8%)

mother was single or had not disclosed the new relationship.

- 4.3.2. When the mother disclosed that she was in a new relationship this was accepted by the midwife and HV1, and was seen as 'not unusual' in this particular geographical area of Somerset. This was explored further during the learning event held for the frontline practitioners involved in this case who talked openly about other cases that they had on their caseloads and that on reflection they 'had possibly lowered their thresholds' and accepted changes of partners without further exploration of the new relationship. The new partner was described 'as supportive' and 'wants to bring the unborn child up as his own', and this was seen as a positive, no further exploration about his background was made (apart from checking whether he was known to any of the services provided by Somerset Partnership). One of the practitioners attending the Learning Event said that they would now "ask probing questions about relationships'. The mother was 21 years old at the time of her pregnancy and the new partner was seven years older than her (this was not known). The mother has been described as 'young' by the midwife and at times difficult to keep a 'thread' on the conversation, as she tended to jump from one subject to another. **Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value.** Professionals must continually assess at each intervention to detect any changes in the family dynamics and think about thresholds of what is 'normal'. The stepfather was a member of a well-known and large extended family who had lived in the local area for many years. At this point there was no background information about the stepfather held within the two agencies involved. I have not made a specific recommendation about professionals' curiosity as the subject is covered within the SSCB Safeguarding training programme and in safeguarding supervision. However, all professionals need to be reminded that they are **tasked to remain in a position of respectful uncertainty and display healthy skepticism.**
- 4.3.3. During the antenatal and postnatal period there is still a culture amongst the professionals that the primary focus is on the needs and circumstances of mothers. This needs to be addressed to ensure that fathers are included and that the contribution they make, the stress that they experience and the risks they may present are properly understood and addressed.
- 4.3.4. The stepfather was known to the Avon and Somerset Police for a variety of reasons, primarily for involvement in domestic abuse with a former partner in 2013. This information was shared with Children's Social Care and the Health Visiting service in respect of the children of his former partner at the time of the incidents. The police conducted Domestic Abuse Stalking and Harassment (DASH)¹⁹ assessments; none of those assessments identified risk beyond the lowest level and therefore no referral was made into the Multi-Agency Risk Assessment Conference (MARAC). However the police had no reason to be aware of the relationship between the mother and stepfather (until an incident in October 2015) and were therefore never in a position to consider any risk to the mother or Sam.

¹⁹ DASH 2009 – all police services and a large number of partner agencies across the UK will be using a common checklist for identifying and assessing risk

- 4.3.5. Somerset Partnership had been notified of the stepfather's domestic abuse in relation to his former partner but he was not registered on the IT system in his own name. Therefore, the Health Visitor was not aware that the stepfather had previously been the perpetrator of domestic abuse.
- 4.3.6. When Sam was three months old, the stepfather had an unexpected and traumatic bereavement; the emotional and mental well-being of both the stepfather and mother deteriorated; both were prescribed anti-depressants, the stepfather lost his job and started to go out drinking during the day and reportedly using cannabis. The mother found it difficult to support her partner as he wanted to go to the grave every day and that his 'loss' had triggered her own grief about the death of her grandmother, she told the Nurse Practitioner that she 'plans her own funeral in her head'. Although the professionals involved suggested attendance at Talking Therapies, accessing parent and child groups; these were not taken up and the situation was allowed to drift with no clear plan in place.

Professionals working in universal services have a responsibility to identify the symptoms and triggers of abuse and neglect, to share that information and work together to provide children and young people with the help they need.²⁰

Information shared by the mother with the Nurse Practitioner was not shared within the practice, nor was it shared with the health visiting team. This was a missed opportunity for staff working in Primary Care to consider and share the information about the family, had this happened then the GP treating the stepfather would have been aware that there was a baby living in the household. GP's need to be reminded about the importance of holding professional meetings within the practice to consider the risks within the family and whether there are safeguarding concerns that need to be escalated. Information sharing by Primary care within and outside of GP practices must be strengthened to ensure that there is a multi-agency approach to support families. In a recent Serious Incident Learning Review²¹ the following recommendation was made:

Information sharing between professionals within health should be reviewed in order to ensure a 'team approach' to supporting families does not put the effective communication of concerns at risk.

- 4.3.7. When Sam presented with a five-day history of vomiting and a floppy episode he was appropriately referred by the Nurse Practitioner to be reviewed by the duty Paediatric team at Musgrove Park Hospital. The Consultant discounted the initial diagnosis made by a junior doctor of gastro-enteritis as unlikely in the absence of diarrhoea. In the conversation with the Consultant, Non Accidental Injury was considered prior to the examination, but Sam was 'bright and alert' and smiling and his examination was normal. The consultant decided that it would be 'prudent' to admit Sam over night, as the history did not fit the symptoms. Sam's head circumference was measured but not plotted; at the time of admission the records from his outpatients appointment were not available and therefore this

²⁰ Working Together 2015

²¹ Serious Incident Learning Review May 2017.

was an isolated measurement. It is not clear whether any enquiry was made with the mother as to whether she had brought the PHCHR (red book) with her, had this been done there may have been some key measurements available to the clinicians. Staff need to be reminded to ask parents at each contact for the PHCHR. If Sam's hospital records had been available and the head circumference measurement plotted it would have shown an increase across almost two centile lines since the outpatient review, and might have suggested the possibility of an intracranial cause for the vomiting. Growth measurements encompass the measurements of height, weight and head circumference. The relationship between these measurements and their trends over time may identify the need for further monitoring or investigations. It is more helpful to professionals when there are a number of measurements over time that provide a more accurate assessment of a child's growth rate. Single measurements are of less value. Sam was discharged the following day by the registrar; there had been no further episodes of vomiting overnight; the discharge summary suggested a possible viral infection.

4.3.8. Although professionals involved with this family had some uneasiness about the family they seemed unclear as to how to respond. 'Soft signs' such as early post-natal discharge, anxiety about the baby's condition but then not acting on the advice given should always be seen as potential indicators of risk and should prompt greater professional curiosity. The professionals working with the family appeared to find it difficult to share their concerns with other members of their own team or with colleagues in other organisations. The health visitors have moved out of GP surgeries which makes 'corridor conversations' less likely to occur. The importance of communication comes up time and time again in Serious Case Reviews, information needs to be shared in order for professionals to be aware and understand the context in which they are working with the family, to understand the situation the child is living in and to determine whether there is a need to protect members of the family.

Recommendation 2: SSCB needs to be assured that partnership agencies identify and respond to the risk and vulnerabilities within families where Domestic Abuse is a concern in order to further safeguard children.

Recommendation 3: Health agencies must ensure that appropriate training is given to all staff working with infants about the importance of measuring, recording and plotting growth measurements, in particular head circumference and weight, in order to recognise when cases may need to be referred for specialist management.

Recommendation 4: Safeguarding Training for health care professionals must highlight the presenting signs and symptoms of brain injuries in young babies, also recognising that brain injury may be present without obvious symptoms.

4.4. Use of thresholds guidance – what guidance was used to develop a single or multi-agency plan of care

4.4.1. The only threshold guidance used to develop a plan of care was by the health

visiting service. The Health Visitor Service in Somerset is the lead agency on the delivery of the Government's *Healthy Child Programme; pregnancy and the first five years*, (DOH, 2009). The Health Visitor Service is required to deliver a Universal service that is made up of core contacts:

- Antenatal – usually between 26 – 38 weeks
- New Birth- usually between 10 and 14 days
- 6-12 weeks
- 6-12 months
- 2.5 years, and if necessary at 3+ years.

Additional support may be needed by some parents and will depend on their individual risks, needs and choices. The aim is to identify any health or development related concerns as early as possible so that the required level of support and intervention can be agreed and if appropriate refer or signpost to another service²².

4.4.2. At the antenatal visit the health visitor assessed the mother as meeting the universal service and this was reiterated at the new birth visit (see 4.2.6). The family was assessed as meeting Universal Plus at the six week visit. The health visiting service was attempting to offer the mother extra support, which she declined. This may have been a warning sign for all the professionals working with the family. Health Visitors, GP's and midwives are part of the Early Help intervention and are the first level of support and intervention within universal services. They are in a good position to be able to help and support families by providing more expert advice themselves, as well as taking on the role of the lead professional for the family and liaising with other professional involved in providing care. Where the need is at a lower level individual services and universal services should be able to provide the necessary support. In effect they should be putting together a Team around the Child (TAC) meeting and a clear understanding of the identified needs of the family and a plan of how the needs would be addressed. This may then have resulted in the case being reviewed at a Healthy Child Meeting. As part of the Healthy Child Programme in Somerset, Health Visitors and getset Early Help Officers (Children's Centres) have a regular forum called Health Child Meeting (HCM). The purpose of the HCM is to provide a formal process for the identification, planning and overview of children and families who require support and multi-agency intervention. The health visitors, midwives and GP's, despite the identification of risk factors and the mother stating that she felt lonely and isolated, did not refer this case, neither did they undertake an early help assessment. This was a missed opportunity for professionals to consider the full family situation, including what information was known about the family and what information was missing and develop a clear plan to help and support the family.

4.4.3. The mother had contact with five different health visitors during the period from the first antenatal contact up to the time of the incident, three of them were the named health visitor for the family, and two were either seen at the Child Health

²² Universal Plus; health visitors provide expert advice on a range of issues, and Universal Partnership, health visitors play a key role in bringing together relevant local services for children and families with complex needs.

Clinic or responded to telephone contact from the mother. HV1 was on annual leave at the time of the new birth so a bank Health Visitor undertook the visit. The family had moved prior to the six-week assessment, which resulted in another change of health visitor and then HV3 commenced a year's secondment, resulting in the family being transferred to HV5. The service works on a federated model with allocation by geographical postcode. With the number of health visitors involved in this case the ability to develop an ongoing relationship with the mother may have been compromised and may have led to a fragmented understanding of the family. Although it is known that her partner is the stepfather of the baby, it became apparent during the conversations with the professionals that not all the health visitors or general practice staff were aware of this. When there are frequent changes of health visitors to a family with a new baby it is imperative that the full history is read and known prior to the visit.

- 4.4.4. The mother was unclear as to the purpose of the antenatal visit by HV1 and felt that the health visitors did not always listen to her. She felt that she was giving them some clues as to her unhappiness in the relationship and wanted them to ask her more direct questions. Her partner was verbally aggressive towards her. She remembers being asked about Domestic Abuse by the Midwifery service but does not think any of the health visitors used Routine Enquiry²³. When she did disclose to HV5 that she was 'going to leave him' she felt that the health visitor told her to give him more time as he was currently under a great deal of stress.
- 4.4.5. When HV5 took over the case she identified a number of concerns and was working closely with the mother to try and support her, and was visiting regularly. HV5 had identified that the mother was isolated and would benefit from attending a local parent and child group and that the relationship between the mother and stepfather was 'falling apart'. Mum didn't feel brave enough to go the group on her own. HV5 could have asked the Children's Centre staff to carry out a joint home visit as a way of introducing the mother to the groups available locally. 'Time Together' offered her a home visit in January 2016; this was after the incident and when Sam was in hospital. The mother felt that it was a pity that this offer came so late on as she felt it might have boosted her confidence had it been offered at an earlier date, and she may have felt able to go to the parent and child group. HV5 also identified that Sam's weight was falling across centiles; his weight was now on the 2nd centile and needed further exploration to exclude any organic reason for the faltering growth.

Recommendation 5: All agencies need to demonstrate that for any unavoidable change of practitioner working with an individual or family, during an episode or intervention is supported by a full and formal recorded handover ensuring all the relevant information is shared, risks assessed and actions agreed. This must include that not only is information handed over, but the handover is received and understood.

Recommendation 6: SSCB need to be assured that thresholds for intervention at level two are being understood and applied.

²³ Screening tool used in Domestic Abuse

4.5. Application of “Think Family” approaches and consideration of the hidden harm factors that may have impacted on the parent’s ability to meet the needs of the child

- 4.5.1. ‘Think Family: Improving Support for Families at Risk’ was launched in 2009 by the Department of Children, Schools and Families. This toolkit was based on evidence of a lack of integrated practice between services provided to children and adults’ and defined ‘Think Family Practice’ as *Making sure that the support provided by children’s, adults and family services is co-coordinated and focused on problems affecting the whole family is important for everyone, and is the only effective way of working with families experiencing the most significant problems.*
- 4.5.2. Services in health and social care are still predominantly commissioned for adult and children rather than for families, the consequence of this is that there is a danger that the impact of risk within the family is not fully understood which potentially leaves adults and children vulnerable. The challenge for the safeguarding system is how to break down professional barriers to achieve change in culture, so that all practitioners see their clients in the context of their family and are willing to work with other service providers.
- 4.5.3. In this case there were clear risk factors in evidence: the break-up of the relationship with the biological father of the baby with known mental health issues, a new partner/stepfather, maternal low mood, child with identified health needs and weight falling across centiles, relationship difficulties, traumatic family bereavement, loss of job, mother becoming increasingly isolated and both parents experiencing mental health issues.
- 4.5.4. Despite this information being shared with the professionals that the family was in contact with not all of them had the complete picture. For example, the nurse practitioner was unaware that Sam’s mother’s partner was the stepfather and the GP treating the stepfather for depression was unaware that he was in a relationship with the mother of a young baby. There was no evidence of any consideration by the professionals given to how these risks may impact on the parents’ ability to meet the needs of Sam, who had identified health needs of his own and his weight gain was faltering.
- 4.5.5. Professionals working with parents should not shy away from discussing the parental personal relationship and the potential impact of these on children. During the conversations professionals expressed that they found it difficult to ask parents about their relationship and assumptions were made that when the stepfather accompanied the mother and Sam to an appointment that he was the biological father. Professionals did not routinely enquire about whom had parental responsibility²⁴. Professionals continued to support the individuals within the family but remained focused on the problem ‘in front’ of them. HV5 identified that the mother was isolated and suggested that she attended local groups to meet other mothers and develop a support network. The onus was on the mother to initiate the contact with the group which, given her depression, was possibly

²⁴ Jointly registering the birth of the child with the mother, getting a parental responsibility agreement with the mother or getting a responsibility order from a court, in the case of unmarried parents.

unrealistic. Health Visitors had talked to the mother on a number of occasions about accessing further support and had suggested that a referral in to early help²⁵ services for an assessment. This was turned down each time by the mother and should possibly have been viewed as an early warning sign by the health visitors working with the family (see 4.4.2.).

- 4.5.6. Currently, systems and services around families can be highly complex and fragmented due to the number of different agencies/organisations involved in delivering care; resulting in fragmented and uncoordinated care. The possible result of this is that the ability to clearly identify the needs and risks within the family as a whole becomes more difficult. There will be a focus on either the child or the adult with little consideration of the interrelated and dynamic context of the family - leaving children and adults without the services that they most need. Professionals who work predominantly with children or adults, can further polarise the assessment of the family as do not always consider the impact of risk from the perspective of the children, or what the child's experience is.
- 4.5.7. Think Family principles are embedded in the SSCB core safeguarding training at level 3. In June 2016 work was done across the county to further highlight 'Think Family' in relation to findings of recent SCRs completed in Somerset²⁶.

Recommendation 7: Partner agencies need to demonstrate that professionals identify risks within the wider family context, assess the impact of those risks on the children and share the information within and across agencies appropriately to facilitate safeguarding of the children.

4.6. How information was shared in the light of the assessment of concerns / risks to the infant pre-birth and vulnerability factors post-birth

- 4.6.1. Lack of information sharing has already been highlighted under section 4.5 of this review. **Further work on how communication and information can be improved between Primary and Community Health Care to further strengthen safeguarding should be undertaken.**

4.7. How well threshold guidance was used to implement a multi-agency plan to address 'hidden harm factors'

- 4.7.1. There was no multi-agency plan to address 'hidden harm factors' in this case.

4.8. To identify if correct learning has been identified from recent Somerset SCRs involving non-accidental injury to infants of vulnerable parents.

- 4.8.1. The subject matter from recent SCRs and single agency reviews in Somerset is similar to this case, in that they involve young vulnerable adults, substance and alcohol misuse (in particular cannabis) and a history of mental health and

²⁵ Get Set, Early Help Services

²⁶ Multiagency Practice Interest Groups (MAPIG) held across the County for practitioners. These were jointly developed and delivered by the Safeguarding Children's Board and the Safeguarding Adults Board in July 2016.

domestic abuse.²⁷ However given that there is some overlap in the timescales for these reviews it is difficult to assess whether the learning identified had had time to be embedded sufficiently in practice.

4.8.2. Information sharing with other agencies within Somerset safeguarding system was also highlighted as being problematic particularly between midwives and health visitors. Since the completion of this review the midwives and health visitors are co-located in the same building and in adjacent offices; anecdotally this has improved communication but an audit needs to be done to ensure that this change has made the desired improvement. The midwives and health visitors now meet on a monthly basis to 'flag' any concerns and midwives now have 30 minute appointments with pregnant women.

4.8.3. It was also identified that there were a number of Health Visitors involved in this case; Somerset Partnership NHS Foundation Trust should review if there is a better way to manage health visitor workload and caseload which would provide continuity for the families and improve health visitor satisfaction.

4.8.4. In two previous cases and again in this one, young babies did not present as cerebrally irritated on admission with a history of vomiting. Training around signs of symptoms of head injuries to young babies must be delivered regularly and professionals should always consider the possibility that this may be the cause for the vomiting. It is well known that babies under one year of age have an increased risk of Non Accidental head injuries. Parental risk factors include:

- young parents,
- unstable family environment
- low socio-economic status, poor early childhood experience including abuse and neglect
- feelings of inadequacy in adulthood and
- social isolation and depression²⁸.

4.8.5. The significance of mental health issues and the relationship to substance misuse and how this may impact on the ability of the parents to meet the needs of their baby is an important feature in all of the cases.

5. Conclusion and Recommendations

This section brings together the recommendations arising out of the learning from Child Sam's experience, which the SCR panel concluded provided insights into safeguarding practice more widely and therefore will require further consideration and prioritization by SSCB.

Recommendation 1: SSCB needs to be assured that all partner agencies have

²⁷ The toxic trio/hidden harm: is abuse or neglect experienced by a child or young person living with parents because of the adult's substance misuse or poor mental health, or domestic abuse or because of a combination of these.

²⁸ Cuthbert et al 2011. 'All babies count-prevention for vulnerable babies: a review of evidence' NSPCC

embedded Multi-agency Pre-birth Protocol to Safeguard Unborn Babies in their practice.

Recommendation 2: SSCB needs to be assured that partnership agencies identify and respond to the risk and vulnerabilities within families where Domestic Abuse is a concern in order to further safeguard children.

Recommendation 3: Health agencies must ensure that appropriate training is given to all staff working with infants about the importance of measuring, recording and plotting growth measurements in particular head circumference and weight, in order to recognise when cases may need to be referred for specialist management.

Recommendation 4: Safeguarding Training for health care professionals must highlight the presenting signs and symptoms of brain injuries in young babies, also recognising that brain injury may be present without obvious symptoms.

Recommendation 5: All agencies need to demonstrate that for any unavoidable change of practitioner working with an individual or family, during an episode or intervention is supported by a full and formal recorded handover ensuring all the relevant information is shared, risks assessed and actions agreed. This must include that not only is information handed over, but the handover is received and understood.

Recommendation 6: SSCB need to be assured that thresholds for intervention at level two are being understood and applied.

Recommendation 7: Partner agencies need to demonstrate that professionals identify risks within the wider family context, assess the impact of those risks on the children and share the information within and across agencies appropriately to facilitate safeguarding of the children.

Appendix 1 Methodology

1.1. Statutory guidance within Working Together requires Local Safeguarding Children Boards (LSCB) to have in place a framework for learning and improvement, which includes the completion of Serious Case Reviews. The guidance establishes the purpose as follows:

Reviews are not ends in themselves. The purpose of these is to identify improvements, which are needed, and to consolidate good practice. LSCBs and their partner organisations should translate the findings from reviews into programmes of action, which lead to sustainable improvements, and the prevention of death, serious injury or harm to children²⁹.

²⁹ Working Together 2015

The statutory guidance requires reviews to consider: “**what** happened in the case, and **why**, and what action will be taken”. In particular, case reviews should be conducted in a way which:

- *Recognises the complex circumstances in which professionals work together to safeguard children;*
- *Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *Is transparent about the way data is collected and analysed; and*
- *Makes use of relevant research and case evidence to inform the findings.*

1.2. The Review directed the independent reviewer to follow a number of lines of enquiry, with a view to reaching conclusions and making recommendations to SSCB:

- Whether pre-birth planning guidance was used or could have been implemented to safeguard the unborn child
- Assessment of vulnerability factors and if protective factors were identified
- Use of thresholds guidance – what guidance was used to develop a single or multi agency plan of care
- Application of “Think Family” approaches and consideration of the hidden harm factors that may have impacted on the parent’s ability to meet the needs of the child
- How information was shared in the light of the assessment of concerns /risks to the infant pre-birth and vulnerability factors post birth
- How well threshold guidance was used to implement a multi-agency plan to address ‘hidden harm factors’
- To identify if correct learning has been identified from recent Somerset SCRs involving non-accidental injury to infants of vulnerable parents.

1.3. In order to meet the requirements above, it was agreed that a mix of traditional methodology and a new learning approach would be used for the review. Agencies provided individual chronologies of events, and these were combined into an integrated chronology. The key agencies were asked to submit a Reflection and Learning Report (R&LR); the reports focused on the agency’s involvement, and they were asked to identify key learning points and areas of good practice. The following agencies submitted R&LR:

- Taunton and Somerset NHSFT Musgrove Park Hospital
- Somerset Children’s Social Care
- Somerset Clinical Commissioning Group
- South Western Ambulance Service Foundation Trust (SWASFT)

- Somerset Partnership NHS Foundation Trust
- Avon and Somerset Police

1.4. The process was led by an independent reviewer who was independent of the case and of all the agencies involved, and worked with an SCR Panel:



Job Title / Role	Organisation
Consultant Paediatrician (Chair)	Yeovil District General Hospital
Strategic Manager	Youth Offending Team
Service Manager	Getset
Associate Safeguarding Nurse	Clinical Commissioning Group
Business Manager	Somerset Safeguarding Children Board
Lead Reviewer	Independent Author
Senior Business Support Assistant (minutes)	Somerset Safeguarding Children Board

1.5. The time frame for the review was from September 2014-November 2015 (the time of the incident). The period under review covers the pregnancy and birth of Sam and the first six months of his life.

1.6. Individual conversations with nine key practitioners were conducted over a two-day period, this allowed the lead reviewer to understand local service provision and what each professional knew and understood about the family at the time the events unfolded in order to avoid the bias of hindsight. Telephone advice was also obtained from Somerset and Avon Police in relation to sharing information about Domestic Abuse. A telephone conversation was also had with the Head Of Midwifery regarding staffing levels; post natal care and the use of routine enquiry for domestic abuse.

1.7. A Learning Event was held with the practitioners involved in the case in February 2017. The practitioners shared their experiences of what it was like to work with the family. The practitioners reviewed 'How Professionals Viewed the Family' and worked in small groups to identify key events and what hinders and what helps practice. The Learning Event was evaluated very well by all staff that attended and they welcomed the opportunity to reflect on this case and what changes they will make to their practice as a result; 'thinking about thresholds of what is normal and continue being curious'. The 'importance of professional curiosity about family members, relationships and the effect on the child' and 'asking probing questions about relationships'.

Appendix 2: References.

Southwest Child Protection Procedures

Somerset Safeguarding Children Board Pre-birth Protocol Version 2.0 October 2106

Somerset Early Help Assessment & Effective Support for Children & Families (Thresholds)

Working Together to Safeguard Children, A guide to inter-agency working to Safeguard and promote the welfare of Children (HM Government 2015)

UK – World Health Organisation Growth Charts, (2016)

Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011-2014 (DfE 2016)

Your child, your school, our future: building a 21st century school system (DfE 2009)

Safeguarding children and young people. The RCGP /NSPCC Safeguarding Toolkit for General Practice. Dr Vimal Tiwara and Dr Matthew Houghton 2014

Non Accidental Head Injuries ‘ All babies count-prevention and protection for vulnerable babies: a review of evidence’ Cuthbert et al 2011(NSPCC)

Appendix 3: Acronyms and Terminology

A&E	Accident and Emergency Department
CHC	Child Health Clinic
CCG	Clinical Commissioning Group
CT Scan	Computerised Tomography
CSC	Children’s Social Care
DASH	Domestic Abuse Stalking and Harassment Tool
DfE	Department for Education
GP	General Practice / Family Doctor
GBH	Grievous Bodily Harm
HCM	Healthy Child Meetings
HCP	Healthy Child Programme
HV	Health Visitor
MIU	Minor Injury Unit
MARAC	Multi-agency Risk Assessment Conference
MPH	Musgrove Park Hospital
NSPCC	National Society for Prevention of Cruelty to Children
NP	Nurse Practitioner
PHR	Parent Held Record
RCGP	Royal College General Practice
SCRs	Serious Case Reviews

SSCB	Somerset Safeguarding Children Board
SWCPP	Southwest Child Protection Procedures

Appendix 4: Actions already taken by Individual agencies.

The following actions were identified by individual agencies at the outset of this Review based on their initial analysis of the practice:

Taunton and Somerset NHSFT Musgrove Park Hospital

1. The Trust has invested in a greater Consultant presence on the Children's Unit. There is Consultant expansion to enable consistent presence up to 10pm. This does not provide strict continuity of care but direct Consultant-to-Consultant handover will mitigate against the risk of this.
2. Ensuring front line staff are appropriately trained in both safeguarding and common paediatric presentations and are able to challenge each other where there is not a clear diagnosis (Responsibility –Named C Doctor and Specialty Tutor)
3. Regular programme of audit including rapid safety audit as above (Responsibility Paediatric Audit Lead).
4. Consideration of the use of tools such as DASH assessment to aid decision making in non-reassuring presentations (Responsibility – Named Midwife).

Somerset Partnership NHS Foundation Trust

Somerset Partnership did not initially identify any learning as part of the agency reflection report, but have since developed an action plan to address the learning identified by the overview author in relation to the findings.

Somerset Clinical Commissioning Group

- It is challenging for clinicians to know how to respond to non-specific feelings of uneasiness about a child or family. Somerset CCG will seek assurance from all providers that safeguarding children training will include specific guidance and examples to help clinicians identify these feelings, and help them to know how to respond.

- It is important, but difficult, for clinicians to ask specifically about paternity; about how parents or partners are managing with a new baby, and how they are getting on together, including making an inquiry about possible domestic abuse. Somerset CCG will seek assurance from all providers that safeguarding children training will include the routine use of bold 'carefrontational' questions.
- Some consultations appear to be focused on clinical examination and don't appear to consider psycho-social issues as well. When patients are seen with mental health problems it is important to ask about their home situation, who they live with, and in particular whether there are any children in the home or whom they have regular contact with.
Key contacts such as Antenatal, postnatal checks, 6 week checks, review of mental health should include review of psycho social issues along with clinical examination. This is already covered in the practice based teaching provided to general practice. Somerset CCG will use a case study to demonstrate to practitioners the importance of this.
- Somerset CCG to undertake a review of EMIS to determine if it is possible to develop computerised medical records that include this information who is in a relationship with the baby's mother.
- Somerset CCG will undertake a review of the use of alerts and flags within primary care.

Avon and Somerset Police

N/A

Somerset Children's Social Care.

When contacts/referrals have been received it should be recorded on LCS that CSC have completed LCS checks on parents or significant others who are involved/living with the child and are named in the contact.

South Western Ambulance Foundation Trust (SWASFT)

N/A The learning relates to the period outside this review.