Somerset Local Safeguarding children board

Serious Case Review in respect of Child Y on behalf of Somerset Safeguarding Children Board

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1. Introduction and Summary

1.1 Child Y was just over three weeks old when Child Y suffered significant injuries whilst living at the home address and in the care of Child Y's parents. Child Y's parents were arrested on suspicion of causing Grievous Bodily Harm to Child Y and a police investigation has been undertaken. Both parents remain on police bail pending further enquiries and in due course a Crown Prosecution Service review of the evidence. Child Y is currently in the care of the Local Authority and is having supervised contact with mother.

1.2 The father is a 22 year old former care leaver who has fathered two previous children with whom he has no contact. One of those children was adopted. The police were called to several arguments between the father and the mother of those children in the 2 years preceding the timescale of this review. Whilst Children's Social Care had no active involvement at the time of the injuries to Child Y, the father was in receipt of care leaving support until his 21st birthday when this ceased by mutual agreement between the father and Children's Social Care.

1.3 The mother was not previously known to social care other than through referrals from the police as a result of their attendance at domestic abuse incidents in 2006 involving her parents and more recently in 2010 – 12 involving her father and step-parents. There was also contact, from Children's Social Care with her school which did not result in any action from the department.

1.4 The police had received information in relation to both parents, separately, as a result of being called to domestic incidents, and to one such incident in which both parents of Child Y were present and the mother was assaulted by her own father whilst she was 10 weeks pregnant with the child who is the subject of this review. This assault was not reported to Children's Social Care, nor was the Unborn Baby protocol instigated.

1.5 Although the midwife who booked the pre-natal care did have some information about the background of the parents she did not identify this as potentially increasing the risks to the unborn child and did not therefore make any referral to Children's Social Care.

1.6 The significance of this information was not identified and therefore was not shared with the Health Visitor, this led to the case being allocated to a student health visitor as 'first time parents with a new baby'. Without any information to suggest that there may be risks to the baby, the student health visitor did nevertheless identify increased vulnerability of the parents, very quickly, but did not identify risks to the safety of Child Y. The injuries to the baby occurred before any professional assessment had been completed and before any intervention had been put in place to safeguard Child Y effectively.

2. Reasons for the Serious Case Review

2.1 Working Together to Safeguard Children 2013 is the statutory guidance provided by government to Local Safeguarding Children Boards and their constituent agencies, which sets out how agencies should work together. It states that Serious Case Reviews must be held for:

"…every case where abuse or neglect is known or suspected and either:

- *a child dies; or*
- *a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child."*[1]

2.2 The Independent Chair of Somerset Safeguarding Children Board determined that the circumstances of Child Y's injuries met this criteria and this serious case review was commissioned in February 2014.

2.3 The purpose of a serious case review is:

- To establish lessons to be learned from the case
- To look at what actions and procedures may need to be changed
- To improve inter-agency working and better safeguard children

2.4 The guidance is clear that:

"Reviews are not ends in themselves. The purpose of these reviews 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 children." [2]

2.5 With this in mind 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;

[1] *"Working Together to Safeguard Children: A Guide To Inter-Agency Working To Safeguard And Promote The Welfare Of Children."* Page 68 HM Government March 2013
[2] *"Working Together to Safeguard Children: A Guide To Inter-Agency Working To Safeguard And Promote The Welfare Of Children."* Page 68 HM Government March 2013

- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

The methodology for this review seeks to reflect these criteria by engaging with the family and the professionals involved at an early stage and throughout the process.

3. Terms of Reference

The review covers the period 8th September 2012 – 1st October 2013, but also references previous history and information where this is directly relevant to the circumstances of Child Y's life and injury.

The terms of reference are to explore:

a) What involvement did agencies have with the parents and child?

b) Did all staff understand and implement the pre-birth protocol? What evidence of this is there?

c) Were agencies aware that the mother and father were victims of domestic abuse during the pregnancy and how did they respond to that information?

d) Was previous history, including of domestic abuse, and previous children, ascertained regarding the parents? Was this information used to inform assessment, planning and decision-making in respect of the unborn child?

e) How did agencies fulfill statutory duties with regard to safeguarding in this case?

4. Methodology

4.1 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 this review. Agencies provided individual chronologies of events, and these were combined into an integrated chronology.

4.2 Ruby Parry from Reconstruct Ltd was appointed as the independent reviewer to write the overview report and to facilitate a learning process that reflects the guidance in Working Together 2013

4.3 Ruby is a former Assistant Director of Children's Social Care with over 35 years of experience in social work and child protection, and she is a registered social worker. Both in her local authority career and as Director of Consultancy for Reconstruct since 2010 she has been involved in over 30 serious case reviews,

either directly or by providing quality assurance and analysis. She therefore meets the criteria for independent reviewer.

4.4 Individual Management Reports were also requested from and provided by:

- Avon And Somerset Constabulary
- Somerset Children's Social Care, Somerset County Council
- Somerset Partnership NHS Foundation Trust
- Somerset Clinical Commissioning Group (CCG)
- Taunton And Somerset NHS Foundation Trust

4.5 These reports were considered at the first Panel meeting on 26th February 2014, which was also attended by the author. The panel comprised:

Ruby Parry	Independent Overview Report Author
Lucy Watson	Panel Chair - Director of Quality & Patient Safety, Somerset CCG

Service Manager – Safeguarding, Children's Social Care, Somerset County Council

Named Midwife for Safeguarding, Great Western Hospital NHS Foundation Trust – commissioned by the LSCB to provide specialist advice to the review

Interim Deputy Director of Children's Services, Somerset County Council

Service Manager – Community Safety, Somerset County Council

Detective Inspector Avon and Somerset Constabulary

Designated Nurse for Safeguarding Children and Children Looked After,

Somerset CCG

LSCB Audit Officer, Somerset County Council

Designated Doctor for Safeguarding Children,

Somerset CCG Safeguarding Administrator (taking notes), Somerset County Council

4.6 This was followed by a development event for all of the practitioners involved in this case which was held in April 2014. The session was facilitated by Ruby Parry and supported by the specialist midwife in order to:

- *Provide professionals with an opportunity to reflect on practice in this case in order to identify and share learning*
- *Inform the serious case review report and agree any practice, procedural or systems change that needs to be covered in the recommendations*
- *Provide constructive feedback to those involved*

4.7 The session was well attended with 12 professionals present, and provided important contextual information for the review as well as evidencing real learning amongst those present (see lessons learned section of this report). The feedback from the event has been positive, although the session would have benefitted from the attendance of a GP the absence of whom limited discussion of those aspects of the case.

4.8 The reviewer and the Safeguarding Manager from Somerset County Council met with Child Y's mother in May 2014. The father was also invited to a meeting on that day but did not attend.

4.9 The initial report was then considered by a further Panel meeting held in May 2014 and also shared with the attendees at the learning event, so that their comments could influence the final review and the recommendations.

4.10 Whilst Child Y's mother was invited to meet with the reviewer to discuss the outcome of the review, she unfortunately did not accept this invitation, so did not see the final report prior to it being signed off by the Panel submitted to the Independent Chair of the LSCB in September 2014.

5. Race, religion and culture

5.1 Child Y's parents are both White British and no religion has been noted to play a significant part in their lives. If the definition of culture is accepted as being 'the way we do things here' then the family culture reflects that of a small rural town in the south west of England, with a close knit community and extended family on the mother's side being close by. The mother describes this as being at times both supportive and intrusive, in that everyone knows everyone else, and with privacy being hard to maintain.

6. Narrative history

6.1 The time scale for the review is very brief and events moved very quickly. However, there is some relevant background information which precedes the circumstances of the injuries to Child Y.

6.2 There is a recorded domestic violence related incident in June 2010 between the mother's mother and her partner. The mother of Child Y is named on the incident and would have been 15 years of age at the time. As previously stated, there were also three domestic abuse incidents reported to the police in 2006 involving verbal altercations between the Mother of Child Y's parents.

6.3 In 2009 the mother's school referred her to children's social care following an incident where her step-father 'pinned her to a wall'. There was a recommendation

that this should be referred to the Local Service Team, but there is no record that this actually happened.

6.4 Between October 2010 and November 2011, there are 5 recorded domestic abuse related incidents between the father of Child Y and his then partner, who is the mother of his previous 2 children. These are recorded as verbal arguments and allegations of physical assault were not made.

6.5 There is also a recorded incident in February 2012, when the mother of Child Y reported that there had been an argument at home with her step mother.

6.6 In December 2012 the parents of Child Y were stopped and searched by the police and the father was found to have a small amount of cannabis on him and was warned.

6.7 Health notes for the father in September 2012 record that he had not attended his appointment at a counselling service for young people nor had he responded to their letter, so was not offered a further appointment. The GP gave him a copy of the letter from the service and he agreed to ring them. He was given antibiotics and medication for 6 weeks for 'depression and anxiety'. The notes do not record further details of his mental state, social history or who he was living with. There is no mention of children.

6.8 The father was also referred urgently at this time to the dermatology department due to a mole on his back but failed to keep two appointments due to what he described as 'money problems'.

6.9 The father is noted to have attended the surgery in January 2013 for 'paternity testing'. This information does not appear to have been linked to his previous history.

6.10 The mother was registered at a different surgery. This was her first pregnancy. Her health notes record nothing of significance.

6.11 In February 2013 the mother called the police to a domestic dispute and assault at her home address when she was 10 weeks pregnant – her father slapped her face and threatened the father of Child Y over money he alleged his daughter owed him. This was not shared by the police with any other agency.

6.12 Health records show that the mother had problems early in her pregnancy with vomiting and stomach upset, and attended the GP for assistance with this. She presented as a gynaecology emergency to the accident and emergency department of Taunton and Somerset NHS Foundation Trust and was referred overnight to the gynaecology ward as she was complaining of abdominal pain. An ultrasound scan excluded an ectopic pregnancy and confirmed a viable pregnancy of approximately 5-6 weeks. She was then discharged home and advised to see her General Practitioner (GP) to book with the community midwife

6.13 She then made frequent visits to the GP surgery with vague complaints or symptoms 'of an unknown clinical cause', usually with abdominal pain / reduced foetal movements / 'query Urinary Tract Infection' including a further hospital attendance where the symptoms resolved on arrival on the ward.

6.14 The mother and the father received maternity care from Taunton & Somerset NHS Foundation Trust. Their booking appointment was held in February 2013 at which a routine social assessment was undertaken as part of the booking process and the father disclosed he had previously been in care as a child. He told community midwife1 that he had two other children, one who lived with the paternal grandparents and one who was adopted. He had no contact with either child.

6.15 According to the maternity records the mother disclosed a stress in her pregnancy from her father, who was volatile, 'mixed drinks' and drank heavily. She shared that her father had slapped her face. It is documented that the mother needed help understanding her pregnancy notes and completing forms.

6.16 In August at 37+ weeks the mother was seen by community midwife 2. The father was also present at this appointment. The community midwife was concerned about the growth of the baby and referred the mother for an ultrasound scan to exclude a small baby. However, there is no documentation of a 2nd social risk assessment on page 2 of the maternity held records, where the information relating to the father's previous children and his time in care is documented, and community midwife 2 did not notice this information.

6.17 In early September 2013 at 10.00 in the morning, the father called the Labour Ward for advice about the mother, as he thought she was in labour. The couple arrived an hour and 12 minutes later, brought in by a female relative. The mother was in advanced labour and Child Y was born by normal delivery 13 minutes after her arrival on the labour ward. Child Y weighed 3070 grams.

6.18 The mother and Child Y were transferred to the postnatal ward where they remained for four hours prior to their transfer home to community midwifery care. Documentation surrounding the discharge arrangements for the Mother and Child Y is very brief. Hospital midwife 3 recalls that the couple was eager to go home. The following day the mother and Child Y returned to the ward for a postnatal and neonatal check, as arranged.

6.19 On day 2, post delivery, the mother was expected to attend her local hospital for a postnatal check with Child Y. She did not attend. Community midwife 2 contacted her by telephone and a telephone assessment took place with a plan for her to attend clinic the next day.

6.20 Child Y was subsequently seen on day 3 at home by community midwife 1. The father of Child Y was present. Child Y was then seen with both parents at the local community hospital on day 5 by community midwife 3, and on day 15 by community midwife 2. Child Y was discharged from midwifery care to the care of

the health visitor on day 15. No concerns were identified by the community midwives who provided care to Child Y during these appointments. Child Y was breastfed and weight on discharge was above the birth weight. The handover of care to the health visitor was by voicemail and sending of the documentation, as was the usual process.

6.21 The case was allocated within the heath visiting practice to a student health visitor (SHV) who was on the third week of her final placement. She attempted to make a home visit to conduct the Primary Birth Assessment. The family were not expecting SHV and did not allow her access to their flat. Instead the father left the flat and met with the SHV on the landing outside where a further date was agreed. The father's rationale for not allowing the visit to go ahead at this time was that the midwifery service was still visiting and the timing was inconvenient.

6.22 The re-arranged visit went ahead and the Primary Birth Assessment visit was completed in line with Somerset Partnership NHS Foundation Trust standards. The SHV gave appropriate advice regarding breastfeeding, safe sleeping and minor childhood ailments. She referred the parents to the GP due to Child Y apparently having oral thrush. The SHV identified that the father dominated the conversation, even those parts of it dedicated to the mother's breastfeeding. As a result she arranged a swift follow up visit for the family. The health records note that the SHV did not begin a formal Family Health Needs Assessment as per local protocol although there is evidence of appropriate assessment in the RiO electronic patient record.

6.23 Child Y was taken to the GP as suggested and the GP has written a statement for police describing the consultation including his concerns about the behaviour of Child Y's father. He reports the father saying *'my job is not to be your friend, my job is to teach you right from wrong'* and perhaps handling Child Y a bit roughly. Child Y was examined and the GP found nappy area thrush as well as oral thrush . The GP rang the Health Visiting team, and left a message on their answer phone. He also sent an internal email to mother's GP, to inform him of this. Oral nystatin and hydrocortisone and miconazole cream were prescribed.

6.24 A telephone message was left on the duty health visitor answer phone for SHV by midwife 2 informing SHV that midwife 2 had concerns about the dynamics between the couple and the potential risk of post natal depression. She left her mobile telephone number as part of the message. The duty health visitor did not respond to this message or record it on the RiO progress notes. SHV did not record this message in the RiO progress notes or return the midwife's call either, but filed the written message with the paper records.

6.25 Next day, the SHV received a follow up telephone call from the GP who reported that when he saw Child Y the previous day due to oral thrush and nappy rash he was concerned about the father's rough handling of Child Y and his inappropriate language to the baby, as documented above. The GP requested that

this family receive a high level of support from the health visiting service. SHV clearly documented this telephone call in the RiO electronic progress notes and discussed with HV1 prior to visiting the family again.

6.26 The SHV returned to the family home a few days later to complete a Neo-Natal hearing screening test. She was accompanied by HV1 as she needed to be assessed completing the hearing screening test, and she had shared with HV1 the concerns raised by the GP, community midwife 2, and her own observations. The father completed all of Child Y's care needs during the contact. The mother reported that she had ceased breastfeeding due to having thrush herself and would seek advice from a GP later in the day. Both SHV and HV1 noted that the father was overtly gentle with Child Y and was talking very kindly to the baby. Both SHV and HV1 agreed that such an overt display of gentle handling indicated that the GP had raised his concerns with the father, and that the father had changed his style of handling Child Y as a result. The SHV successfully completed Child Y's neonatal hearing screening test which was clear in both ears. She gave the mother appropriate advice regarding the treatment of thrush and breast care and signposted both parents to the Parent Held Child Health Record regarding further information on normal hearing and speech development. She also arranged the next planned health visitor visit to include the Teenage Parent Champion, who would be introduced to the family to offer them extra support and advice regarding positive parenting.

6.27 The next day, the father made an urgent appointment with the GP at 12:10 as Child Y at 19 days old, was *'pale and sweating, coming straight down'* but the family did not attend until 14:15 as Child Y was *'being fed and changed.'* This was too late for the morning surgery and the family were offered an appointment later that afternoon but declined. *'Dad decided to speak to Health Visitor this pm, he noted colour back and sleeping content. He will ring again if concerned'*[3]

6.28 Later that day the father telephoned the SHV who agreed to see Child Y at the Minor Injury Unit of Bridgwater Community Hospital as the father was concerned that Child Y was pale and unwell. The father stated that he had been unable to make a GP appointment for Child Y and had been advised by the GP practice to contact the health visitor instead. The mother informed the SHV that she had not had any concerns about Child Y's condition. SHV observed Child Y in the pram to review Child Y's colour and touched Child Y's cheek to check Child Y's temperature. She did not request that Child Y was removed from the pram for a more thorough assessment as Child Y was asleep, and she had no access to an examination room at the clinic. Instead, she advised the couple to call NHS Direct, the Out of Hours GP service or to attend the Minor Injury Unit if they remained concerned about Child Y's condition.

6.29 Four days later, the SHV returned a telephone message from the father, (left on her mobile early in the morning outside of office hours), who stated that Child Y

[3] EMIS – GP surgery notes

was pale, not taking as much milk as before and appeared to be shaking at times which he compared to an epileptic fit. SHV advised the father to make a GP appointment for Child Y. SHV noted in the electronic record that the next planned contact with the family was in a few days time.

6.30 The GP surgery recorded that the father made an appointment but later rang the surgery to say they were just leaving & would be late. They were subsequently seen by GP4 that afternoon and the father described a history of odd episodes of jerks from 05:30 that morning. The GP made a careful examination, including holding Child Y, and noted him 'jerking'. He therefore made an urgent referral to a paediatrician at the hospital and agreed that the family would take Child Y there as they had a car waiting outside. The PA then rang the hospital twice to check that Child Y had arrived.

6.31 On attendance at hospital Child Y was examined and an MRI scan indicated that Child Y had survived a subdural haemorrhage, which is bleeding in the brain and is commonly associated with 'shaken babies'. The injuries were subsequently noted to be up to seven days old, but some likely to be considerably more recent.

7. Analysis

7.1 As stated previously the review concerns a short period of time where events moved very quickly indeed.

7.2 Events will therefore be analysed briefly against the terms of reference, then within a research and evidence framework in order to draw conclusions and identify the lessons learned by professionals involved in the case as well as the learning for the wider membership of the Safeguarding Board.

a) What involvement did agencies have with the parents and child?

7.3 The involvement of Children's Social Care's (CSC) with Child Y dates from the beginning of October 2013, when a referral was received from Musgrove Park Hospital (MPH) indicating that the baby had been admitted with seizures and suspected non accidental injuries due to shaking. Child Y was not referred to CSC prior to birth, nor prior to admittance to hospital on the above date. This is unfortunate as the department held information about both parents which would have raised some concerns about their vulnerability as parents and potential risk and support needs for their baby – see below.

7.4 The initial contact with CSC was made to the out of hours Emergency Duty Team (EDT), and was processed as a referral by Somerset Direct Telephone Contact Centre (SD). The Team leader at Somerset Direct correctly identified that due to the serious nature of the referral, a strategy discussion was needed. The referral was sent electronically to the CSC Area office where the

assessment team leader had an initial strategy discussion with the Police Safeguarding and Coordination Unit (SCU) at which it was agreed that a 'sit down' strategy meeting was needed. This strategy meeting took place at 1pm on the same day at the hospital, and was attended by CSC, Police, Health Visiting Service and a Consultant Paediatrician from the hospital.

7.5 This meeting shared information from the above agencies, and a further strategy meeting between Police and CSC took place on the following day. The above meetings agreed that CSC needed to consider an application to the court for an Interim Care Order, in order to ensure the safety of Child Y, and a legal case discussion chaired by the CSC Area manager took place on the same day at which it was agreed that an application to the court was needed.

7.6 Child Y was moved to Paediatric Intensive Care Unit (PICU) in Bristol, and CSC case records indicate ongoing liaison between CSC and hospital staff.

7.7 Five days later, a further strategy meeting took place, attended by CSC, Police SCU, and Paediatrics (MPH). Information shared at the strategy meeting indicated that the injuries noted to Child Y were 'highly suggestive' of a Non Accidental Injury (NAI) caused by shaking.

7.8 A week later, a discharge planning meeting took place at the hospital, which agreed that Child Y would be discharged from hospital in to foster care on 17 October. The meeting was attended by CSC, Police, Children's Physiotherapy, named Nurse for Safeguarding, Health visiting Service, the mother and the Consultant Paediatrician.

7.9 The following day, CSC made an application to the family court for an Interim care Order, which was agreed. This order allowed the Local authority to share parental responsibility with the parents of Child Y, whilst retaining the power to make decisions in Child Y's best interests.

7.10 As outlined in the narrative of events, the police had some contact with both parents prior to the birth of Child Y. There were 3 calls to the police over 3 years in relation to the mother and 5 calls to the police in relation to the father and his previous partner, during 2010-11. This indicates that both the parents had experienced vocal and aggressive arguments and in the father's case, he had been on occasion the perpetrator. However, only one of these incidents involved Child Y – the assault on the mother in February 2013 when she was 10 weeks pregnant with him, whereby her father slapped her face. This was closed by the officers when they had clarified that the victim, the mother, was not living with the perpetrator.

7.11 The main professional contact was with the health services. The parents were registered at 2 different surgeries and there were 4 GPs involved at various points with the parents and Child Y.

7.12 The family also received maternity services from the Taunton and Somerset NHS Trust. This included ante-natal and post natal care from 3 midwives, as defined within NICE guidelines, although the level of assessment at the point of Child Y's birth and hospital discharge was limited and did not include a social assessment as the mother did not wish to stay in hospital and left within 4 hours of the birth, declining any additional support. The family was then referred to their local health visiting practice, 14 days after the birth where they were allocated to a student health visitor who was three weeks into her final practice placement.

7.13 Two different hospitals also had care of the mother during pregnancy and then for Child Y at admission to hospital with the injuries which led to this review. However, although the mother was cared for in two different hospitals, this was with the same NHS Trust and care provider who provided maternity care on two sites

b) Did all staff understand and implement the pre-birth protocol? What evidence of this is there?

7.14 There is no evidence that the Unborn Baby Protocol was considered, because the risks were unrecognised by those involved. The protocol can be easily accessed by a maximum of 2 clicks on a computer mouse on the electronic South West Safeguarding Procedures web-site at www.online-procedures.co.uk/swcpp where it is clearly stated that "*Under 1's are 7 times more likely to be killed than other age groups*'. There is also a very clear statement that ***"'Wait and see' is not a safe option and wastes valuable time to intervene."***

7.15 There were several opportunities where this protocol could have potentially have been instigated to protect the unborn child.

7.16 The first was when the police attended the domestic incident on in February 2013 when the mother was slapped across the face by her father and told the police that she was 10 weeks pregnant. She stated that this was not the first time her father had assaulted her and she had fear for herself and her unborn child. She described her father as controlling when she was living with him and if she did not do as she was told or do anything he did not like he would become angry or violent. She also alleged that over a year previously he had returned home drunk and had become angry, grabbed her around the throat and his 'wife' intervened. She alleged that he drank alcohol a lot, and had assaulted other family members (mother, her new partner and mother's best friend).The officers advised the mother to get checked out at hospital. The police DASH risk assessment was completed correctly and all relevant questions were asked. The police officers assessed a medium level of future risk and passed the information to the Police Safeguarding Unit which did not notify CSC about this incident.

7.17 The police IMR confirms that police staff working within the Public Protection Unit are generally aware that there is a pre-birth protocol available on the South West Child Protection Procedures web site. The IMR states that the staff at all three of the Police Safeguarding and Co-ordination Units were also aware of these

procedures and of the need to inform partner agencies of incidents involving pregnant women.

However, the author acknowledges that: "*there is limited knowledge of the protocol amongst wider Police staff and it is invariably uniform officers who attend such incidents*". Whilst "*The safeguarding units provide a test and check second risk assessment process to ensure that relevant referrals are made to Children's Services for domestic abuse incidents involving pregnant females as it is part of the questioning on the DASH risk assessment*"(police IMR para.4.2) the DASH in this case did not result in consideration of the protocol. This was because the attending officers did not identify any ongoing or significant risk to the victim or to the unborn child and graded the DASH as medium risk. The significance of the unborn child was not picked up either by the attending officers or the unit, and no referral was made to Children's Services in line with the protocol.

7.18 The learning event also identified some confusion about the threshold for using the protocol as the unborn child was only 10 weeks gestation at this point. The protocol on the website states that: "*You should follow up concerns from as soon as possible, by 12 weeks gestation".* This seems very clear, but is dependent on a professional identifying that there is a concern in the first place and this did not happen at any point during the pregnancy.

7.19 Staff at the hospital also missed this opportunity in January 2013 when the mother presented with unspecified stomach pains. She was swiftly moved to the Women's Health Unit in line with hospital protocol and there is no evidence that domestic abuse was routinely considered there as good practice would suggest. Unspecified stomach pain in pregnancy is a known indicator of potential domestic abuse but in fairness would need to have been considered alongside other risk factors, about which the hospital had no information, and staff do not appear to have enquired about this aspect of mother's social history.

7.20 The third opportunity to instigate the protocol was following the assessment at the maternity booking appointment in February 2013 where the father shared some of his history with community midwife 1 and the mother also related her history of domestic abuse and associated stress. At the learning event community midwife 1 confirmed that at the time she was not familiar with the protocol, but did consider whether she should refer the family to social services. She decided not to do so as they were so open, apparently honest and very much a partnership. She felt that she 'wanted to give them a chance to make a go of it', having seen parents who had far more obvious difficulties including drug abuse have their children returned to them by social care. She found them to be very plausible and did not give sufficient weight to the history they shared with her or see this in terms of risk factors, although she did record this information on the maternity held notes. This optimism is a mistake she regrets and will not make again. Having met the mother it is easy to see why community midwife 1 would have been optimistic – she presents as being very child focussed and sensible and also totally delighted to have been pregnant.

7.21 The fourth opportunity was when the 2nd risk assessment was carried out by community midwife 2 and again no social risks were identified. There was no formal sharing of the joint caseload and therefore no direct midwife to midwife handover of

the case that may have acted as a failsafe and alerted either midwife of the need to escalate/investigate further, in view of the fathers' disclosure. Community midwife 2 did not refer back to the original booking assessment where his disclosure relating to his previous children was documented and another opportunity was missed.

c) Were agencies aware that the mother and father were victims of domestic abuse during the pregnancy and how did they respond to that information?

7.22 As above, the full extent of this information was known solely to the police. The police IMR notes that: "*From a Police perspective there is no evidence or information to confirm that this information was used to inform assessment, planning and decision making in respect of the unborn child.*

The incidents not subject of the terms of reference for this IMR have been recorded correctly. There is evidence for some of these incidents that appropriate referrals have been made to Children's Services. For many of the incidents a DASH risk assessment was not completed. In hindsight this is a missed opportunity to identify risk factors."

7.23 The details of the earlier incidents were shared with Children's Services, but unfortunately the one incident in which the fact of the mother's pregnancy and her relationship with the father was noted was not shared with them. It is standard practice in Somerset Children's Services that all domestic abuse notifications from the police are subject to internal records checks. This would have identified the father as a former care leaver with a history of significant difficulties and an adopted child and the mother as a vulnerable young person due to a history of domestic abuse between her parents. The combination of the history of the two parents should have raised concerns and may well have resulted in multi-agency action to safeguard their unborn child.

7.24 The mother's GP and community midwife 1 were aware of the assault on the mother by her father in February 2013 but not of any other incident, and this by itself would not necessarily have alerted any professional to potential risk.

7.25 Community midwife1 was reassured in conversation with the mother that she had no contact with her father and therefore did not see the single incident as domestic abuse or as a risk to either her or the unborn child. Community midwife 2 did not then ask the domestic abuse question when she completed the second assessment on her 5th contact with the couple at week 37.

7.26 Community midwife 2 became concerned about the father's dominant presentation following the birth of the baby and contacted the health visiting services to alert them to this during the transition period to that service. This is the only occasion in which the possibility of domestic violence or abuse within the relationship was considered.

7.27 Prior to this the issue of domestic violence or abuse was not discussed with the mother either when she attended GP appointments or in her appointments with other health professionals through her pregnancy – for example when she attended hospital for the second time in June 2013 with concerns about abdominal pain, and on her visits to the midwife for ante-natal care in April and August, when the

chronology records that she was not accompanied by the father. Good practice states that this is a standard question that should be asked of any pregnant woman, and also in this case because there were two presentations with abdominal pain which may have indicated abuse. The mother's history of domestic abuse within her own family may also have made her more vulnerable and more tolerant of further abuse, which is an additional risk factor.

7.28 The importance of the understanding of professionals and of the general public about what constitutes domestic abuse is a key factor arising from this review. On arrest, the mother told the police that there had been no domestic abuse in her relationship. She subsequently advised the reviewer that had she been asked about this before she would have said the same. She had witnessed violence in the relationship between her parents and had this as her reference point for what constitutes domestic abuse. However, since Child Y's injuries she has looked at some leaflets and has contacted a domestic violence charity as she now understands that much of the father's behaviour towards her was in fact abusive.

7.29 The mother of Child Y described a highly controlling partner who withheld her money and dictated who she could see and where she could go, undermined her confidence and isolated her, and who would fly into a rage if he thought that she was talking to other men. She also described his jealousy when the baby was born and was taking up so much of her attention.

7.30 The NHS Choices web site describes domestic abuse in the following way:

Domestic Violence is officially classified as "any incident of threatening behaviour, violence or abuse between adults who are or have been in a relationship together, or between family members, regardless of gender or sexuality".

We think of domestic violence as hitting, slapping and beating, but it can also include emotional abuse as well as forced marriage and so-called "honour crimes".

It's abuse if your partner or a family member:

- *threatens you*
- *shoves or pushes you*
- *makes you fear for your physical safety*
- *puts you down, or attempts to undermine your self-esteem*
- *controls you, for example by stopping you seeing your friends and family*
- *is jealous and possessive, such as being suspicious of your friendships and conversations*
- *frightens you*

7.31 The mother stated that she understood domestic abuse as being physical violence and as the father had not hit her she did not recognise that she was being abused. Professionals would have had to ask her very specific questions covering the bullet points above to elicit any positive response from her. Simply asking if she was frightened of her partner or if he was abusive to her would not have been enough.

7.32 This is important because research tells us that women who live with controlling and abusive partners often blame themselves, and struggle to protect their children from the impact of the abuse. Indeed domestic abuse is a significant risk factor in the emotional and physical abuse of children and in neglect. [4] This is particularly important in relation to babies who are most vulnerable to death and serious injury.[5]

7.33 The same NHS web-site states that: "*Thirty percent of this abuse starts in pregnancy, and existing abuse may get worse during pregnancy or after giving birth.*

Domestic abuse during pregnancy puts you and your unborn child in danger. It increases the risk of miscarriage, infection, premature birth, and injury or death to the baby."

7.34 The website features a midwife talking about this issue which suggests that the NHS nationally takes the role of midwives in detection seriously. It is of concern that this did not translate into local practice and the feedback from health staff identified that this web-site is not widely referenced by frontline staff, so that this definition of abuse may not be well understood by them. The midwives in this case describe a clinically focused service in which a huge range of clinical questions have to be asked and entered on to the records at each appointment, in line with national policy.

7.35 One midwife stated that "..*sometimes, if you haven't got that little switch, if you haven't experienced this before, you will give the benefit of the doubt and miss things…."* Unfortunately other serious case reviews support this perspective, in that front line midwives are not always the best trained and supported to recognise and deal with this issue – this is discussed further in the lessons learned section of this report.

[4] For example, Cleaver, H. Unell, I. and Aldgate, J.: *Children's Needs – Parenting Capacity*. *The Impact Of Parental Mental Illness, Learning Disability, Problem Alcohol, Drug Abuse And Domestic Violence On Children's Safety.* (2nd Edition) 2011 London The Stationery Office

[5] Brandon et al *"Analysing Child Deaths and Serious Injury Through Abuse and Neglect: What Can We Learn? A Biennial Review Of Serious Case Reviews* (2003-5, 2006- 8, 2009-11)

7.36 It is also of concern that the national web site interchanges the use of the terms ‘domestic abuse’ with ‘domestic violence’ as this gives a confused message and can be interpreted by the public and by professionals as being about violence – a very serious and dangerous issue - rather than the control and emotional abuse which is a feature of such abusive relationships and often a precursor to physical violence. The national definition on the Gov.uk website is “domestic violence and abuse”.

d) Was previous history, including of domestic abuse, and previous children, ascertained regarding the parents? Was this information used to inform assessment, planning and decision-making in respect of the unborn child?

7.37 The Somerset Clinical Commissioning Group IMR records the following:

“*The father had been registered at Surgery 2 since 2004. His past history from the Vision computerised record clearly records his troubled childhood, history of fire setting, depression and self-harm, involvement with CAMHS, and time spent in Care. He has a past history of several overdoses, requiring hospital admissions; he was seen by Somerset’s Mental Health Crisis Team in 2011. He was referred to Right Steps Counselling Service several times for anxiety and depression, but did not engage with them. There is no record of violence or drug misuse. He has 1 daughter who has been adopted. He took medication for depression(sic)daily very sporadically, but no prescriptions ……have been issued since December 2012.*

Over the period of the review he had two face to face appointments with GPs, and two telephone appointments. These consultations often contained multiple problems to be dealt with.

The father was certified as unfit to work because of anxiety and depression in September 2012.”

7.38 Surgery 2 was the only professional agency involved at the time that had this information. The GP did not know that the father was about to become a parent again as he did not tell them and the mother was registered at a different practice, Surgery 1, as was Child Y when born. There was no point at which this information was requested or accessed by any of the other health professionals involved, all of whom used different case record systems which did not provide cross practice or service information about patients. This was usual practice.

7.39 However, the fathers' RiO electronic mental health records were reviewed following the incident and revealed much fuller information that would have been significant if it had been available to professionals prior to the injuries to Child Y – midwives do not have access to RiO but health visitors do have access:

(The father) was not a first time parent but has two older children, a six year old male child who lives with a grandparent and a four year old female child who has been adopted. He.. does not have contact with either child. In fact..he..and his previous partner, were placed in a Parenting Assessment Unit following the birth of their daughter due to concerns about their ability to safely parent the child due to their anger issues and joint drug misuse. The placement was not successful. (The father) has a significant risk history of violence and aggression and had convictions for shoplifting by the time he was fourteen years old. He had been excluded from school. He was referred to Somerset Partnership CAMHS in 2004 when his mother was unable to cope with his escalating difficult behaviour some of which was directed at his two younger half-sisters. His relationship with his mother deteriorated and he later become Looked After by the Local Authority… By the age of sixteen years he had developed a depressive illness, self-harmed and attempted suicide several times; he was referred to the Somerset Partnership Crisis Resolution, Psychiatric Liaison and Community Mental Health Teams on several occasions. (He) reported using cannabis from the age of eleven years….experienced periods of homelessness after being evicted from (his housing) for aggressive behaviour."

7.40 Health visitors are usually informed of all pregnancies via caseload and due dates, and should have been aware of this pregnancy. However, the Somerset Partnership IMR states that the Health Visiting Service was not informed of the mother's pregnancy by either the GP or midwife. Instead the first notification the service received was from Child Health when Child Y was born. As a result there was no opportunity for an ante-natal assessment to be carried out in the ante-natal period by the Health Visiting service, missing a chance to identify the father's previous risk history – this would have included accessing the Rio records.

7.41 Although the SHV did check the Rio records, she did not have a date of birth for the father and did not access Mental Health records – see below. This important background information did not therefore come to light, and the professionals involved worked only with what was presented to them.

7.42 Surgery 1 had no information about the father. The information held on the mother's medical notes was that "*The mother had no current mental health illness and there was no family history of mental health disorders*." It is recorded by the GP and by community midwife 1 that when asked about street drugs and alcohol she said she did not use either. They therefore had no apparent reason for concern.

7.43 At the booking appointment the IMR notes that midwife 1 "*documented that she discussed healthy eating, vitamins, employment rights, maternity benefits,*

effects of smoking on mother and baby, travel safety and seat belts, stresses in pregnancy, support at home, sex in pregnancy & exercise, all of which are required in this initial appointment. The father disclosed he had previously been in care as a child, and had two other children, one who lived with the paternal grandparents and one who was adopted. He had no contact with either child. The mother disclosed a stress in her pregnancy from her father, who was volatile, 'mixed drinks' and drank heavily. It is documented that (the mother) needed help understanding her pregnancy notes and completing forms". Community midwife 1 disputed that the mother disclosed this information at booking, but she did record it as a 'third hand' comment on the midwifery held notes. The midwife did not know about the father's history of domestic abuse, or his mental health issues and aggression and did not therefore understand the relevance of the information in terms of potential risks to the baby.

7.44 Community midwife 1 also noted that the mother needed help with the forms and leaflets and had a learning difficulty of some kind, although the midwives later stated that this was no more than for many other patients with whom they were working.

7.45 As above, community midwife 1 felt that they were a pleasant and plausible young couple who 'deserved a chance' and she did not enquire about social services involvement or seek to refer the couple on for further support. This is a training and supervision issue that is further discussed in 'lessons learned' at Section 8 of this report.

7.46 The Taunton and Somerset NHS Foundation Trust IMR records that:

"*At 37+ weeks (the mother) was seen by community midwife 2. The father was also present at this appointment. The community midwife was concerned about the growth of the baby and referred (the mother) for an ultrasound scan to exclude a small baby. A 2nd risk assessment was carried out and no social risks were identified. However, there is no documentation of a 2nd social risk assessment on page 2 of the maternity hand held notes, where the information relating to the father's previous children and his time in care is documented. This information does not therefore appear to be included in any future discussions or written records about the couple – there was also no liaison (about this case)between the two midwives*."

7.47 As previously stated, community midwife 2, who job shares with community midwife 1 and shares a case load with her, carried out the second risk assessment and did not note any concerns at the time so completed the relevant sections in the patient held notes but did not add to the maternity held notes or note their contents. She did not therefore note the background and like community midwife1 she was reassured in conversation with the mother that she had no contact with her father and therefore did not see the one incident as a risk to either the mother or the unborn child.

7.48 The community midwives stated that they discussed their caseload daily at work. They also had formal meetings to discuss 'problem' cases monthly with the two Health Visitors assigned to the Doctor's surgery at the time. As no risks had been recognised this case was not identified by either midwife as needing discussion in that forum.

7.49 As stated previously Children's Social Care held significant information about both parents. This included the following:

- In 2006 the police made three referrals of verbal altercations, two with violence, between the mother's parents who were in the process of splitting up.
- In 2009 they received a referral from the mother's school regarding an argument between the mother and her step-father, which resulted in the mother being physically restrained by her step-father. No further action was taken by CSC. Case notes indicate that a referral to the Local Service Team should be made to support with the mother's behaviour problems, however there is no evidence to indicate that this referral was made.
- In 2010 there was a further referral from the Police regarding a domestic incident between the mother's mother and step-father. Step-father is alleged to have assaulted the mother's mother and smashed items in the home. The referral included significant and concerning details of domestic violence. He had never assaulted the mother of Child Y but had his ex-wife. The CSC database indicates that the family was visited by a social worker and no ongoing involvement was identified as being necessary. No assessment was recorded however.
- In 2011 the mother's school again referred her to CSC as one of her friends alleged that she had been assaulted during a visit to London. CSC discussed the situation with school staff and agreed that the school would provide support to the mother if needed.
- Finally in 2012 there was a referral from MARAC as the mother's father and step-mother were discussed there. No actions were noted for CSC, and they took no further action.

7.50 In relation to the father, CSC records show the following:

- The father of Child Y was looked after by the local authority from October 2005 to March 2007. He spent the majority of this time in residential care, but was accommodated within a foster placement briefly. The father went on to be supported by the Leaving Care service until he was age 21, when this contact ended by mutual consent. The father had been voluntarily accommodated due to the breakdown of his relationship with his mother, who felt she could not manage his behaviour in the home environment. As a child, the father engaged in low level criminality, and was known to use cannabis, with his mother's agreement.

- The father has two other children that are known to CSC. The first was born to a young woman who was in care with him. The father did not at any stage provide care for this child, whose mother was in a relationship with another man.
- The second child was referred to CSC by the maternity unit shortly after its birth. There was no CSC involvement with this child pre-birth. Due to the serious concerns raised about the father and the child's mother's ability to provide safe and positive care for this child, both parents and the child went to a residential parenting assessment placement. The father left this placement and did not seek any further assessment with regard to caring for his child who went on to be adopted.

7.51 As Children's Social Care were not contacted by other professionals at any point, this information was not pulled together and there was at no point therefore any collation or assessment of risk factors that would have alerted professionals to the need to jointly plan for the safety and welfare of the baby.

7.52 However, worryingly, the mother described to the reviewer a visit with the father to the social worker for his adopted baby to collect pictures of the child. The mother was visibly pregnant at that time and the couple told the worker about the pregnancy and their joy that they were to be parents. It is of concern that this worker did not note the significance of this information given the history of the father and refer the couple to the children's social care duty team for assessment and support.

e) How did agencies fulfil statutory duties with regard to safeguarding in this case?

7.53 None of the agencies involved can be said to have acted proactively to safeguard Child Y and opportunities to do so in the ante-natal and birth period were missed.

7.54 Research undertaken by Reconstruct, and presented on the South West Child Protection Procedures website identifies a number of risk factors which may have been identified in this case:

"*When to be concerned*

- *Worries about either parent's current behaviour, e.g. known mental health concern or substance misuse*
- *Concerns either parent/carer may not be able to care for the baby to an acceptable standard, e.g. significant learning difficulty, previous neglect or other children subject to child protection plans/taken into care*
- *The behaviour of others (including fathers) may pose a threat to the unborn baby, e.g. domestic abuse or known allegation or conviction for offences against children under 18 years of age*

- *The impact of one parent's behaviour on another may be reducing their ability to care for the baby to an acceptable standard*

- *If the mother is unable or unwilling to say who the father of the child is*"

In addition the following individual factors applied:

Mother

- History of family discord and violence,
- Family breakdown
- Historical abuse
- Young parent
- Isolated

Father

- Family breakdown
- Young parent
- History of care
- Previous children subject to care proceedings
- Drug use
- Mental health problems – depression and anxiety

7.55 However, no health professional was aware of all of these factors and information was not brought together to inform planning as there was no contact with social care where much of this information was stored about the parents on their individual records. Social Care was at no point formally informed that the mother and father had developed a relationship and were having a baby, although there was a missed opportunity when, according to the mother, the parents attended a social care office to collect photographs of the fathers' adopted baby and shared with that worker their impending parenthood.

7.56 Therefore although there had been significant involvement by Children's social care with the father prior to his leaving care, they were not involved with Child Y until notified Child Y's injuries in early October 2013. This is hugely unfortunate as they were not therefore in a position to safeguard Child Y. However, the visit to the adoption service in April 2013 when the parents shared their joy at the prospect of being parents was a missed opportunity to safeguard the unborn baby and instigate the Unborn Baby Protocol.

7.57 The action taken by CSC when notified of Child Y's injuries is in line with guidance in Working Together 2013, which indicates that a social worker must make a decision regarding further action within 24 hours of receipt of the referral. Working Together also indicates that where there is concern that a child may have suffered

significant harm, a multi-agency strategy discussion should take place to ensure the child' welfare and plan future action.

7.58 Where the local authority is concerned that a child may have suffered significant harm, an assessment of the child must be completed within a maximum time scale of 45 days. In this case, a Child and Family Assessment was completed, 15 working days after the receipt of the initial referral.

7.59 In relation to the police, the IMR notes that the incidents not subject of the terms of reference for the review had been recorded correctly. There is evidence for some of these incidents that appropriate referrals had been made to Children's Social Care. For many of the incidents a DASH risk assessment was not completed. In hindsight this is a missed opportunity to identify risk factors.

7.60 The midwifery service had determined early on that the couple were trying hard to meet the needs of their unborn child and were 'given the benefit of the doubt'. This view of the couple meant that no risks were identified to inform the allocation of health visiting and the actions that followed. The fact of the father's care leaver status and previous child did not make it onto any transfer notes to the health visiting service, and indeed no transfer notes, electronic records or handover discussion were provided to the allocated Student Health Visitor.

7.61 When the mother was in advanced labour in the hospital the Taunton and Somerset NHS Foundation Trust IMR identifies that "*One of the midwives described feeling "there was something about", the behaviour of (the father). She described his behaviour as not appropriate, in terms of him trying to focus attention on himself. (The mother) was in advanced labour and (the father) wanted to talk about his own experience of labour in relation to the births of his previous children, which she felt was odd.*

The midwife was concerned enough to check the high risk folder on labour ward (in which copies of any pre-birth safeguarding planning are kept). She found nothing relating to (the mother) and was therefore reassured."(3.11)

7.62 Review of the booking paperwork at this point may well (combined with the concerns about the father's behaviour) have triggered her to escalate or discuss her concerns with a senior midwife. It is also unfortunate that the absence of previous recorded concerns served to reassure the midwife that her own judgement was not worth further follow up. In addition, the birth of Child Y so soon after arrival meant that there was no opportunity for a fuller health and social care assessment which mother's early age and the midwife's concerns should have triggered.

7.63 The IMR goes on to state that the mother and Child Y were transferred to the postnatal ward, where they remained for four hours prior to their discharge home to community midwifery care. The booking and subsequent social risk assessments were not reviewed or taken into account at all prior to transfer home. In particular,

there was no consideration of the mother's age (18) and the fact that she may need additional support because of this. The couple were very keen to go home as soon as possible. The IMR author states that it is very unusual for teenage mothers to request such an early discharge; however this was not challenged at all despite the lack of any real assessment of health and social care needs. Assumptions were made that because there had been no referrals/safeguarding alerts that there were no additional support needs or issues. Review of the booking disclosure may have triggered further investigation but this did not occur and what assessment there was at this point was therefore severely limited.

7.64 The mother has stated that she had a fear of the hospital because her grandmother had died there recently and this caused stress for her. She felt that this would impact on Child Y and therefore pressed to be allowed home.

7.65 Following Child Y's birth a SHV was allocated this family at the weekly allocation meeting held by the Health Visiting team in which she was based. Her experience of the allocation process was that new births were allocated on a random basis, dependant on the existing workload held by the Health Visitor receiving the new case. New cases had not been reviewed prior to allocation taking place to identify potential or actual risk factors and other likely complexities, and the lack of any handover from the maternity services meant that what information there was available was not shared, including the fact that these were teenage parents and whether a referral had therefore been made to the Teenage Pregnancy Link Health Visitor.

7.66 The IMR found that since the reorganisation of HV services into "hubs" there has been a local agreement with the Teenage Pregnancy Link Health Visitor for the midwife to send a copy of the front page of the eClipse Booking Form as a process for informing the HV service of teenagers (instead of the communication form being used by midwifery). This agreement therefore introduced yet more confusion. The health visiting services state that no form was received by them, although there is a copy of this form in the notes annotated "FAO teenage Link HV" and the community midwives confirm that it was sent. However there is no fail safe process for ensuring the HV has received the form and no process for community midwife follow up. Furthermore the Student Health Visitor was not aware that a local agreement was in place for the Midwifery service to share this information with the Teenage Pregnancy Link Health Visitor.

7.67 The receipt of a communication form (or indeed the eClipse form) would have initiated a visit from the Teenage Link HV to visit the mother while she was pregnant.

7.68 Without any of this in place the case therefore appeared to be perfectly suitable for a Student Health Visitor in the consolidated element of her training for three weeks at the time. Had there been some checking of the Rio system prior to allocation, the father's history may have come out and there may well have been a

different outcome. As a minimum, it may have been considered more appropriate to allocate the case directly to the Young Parent Champion ensuring that the family would not have an early change of health professional and providing continuity of care with an experienced health professional.

7.69 However the Somerset Partnership Foundation Trust IMR states that:

At the time of this incident the Health Visiting service were still embedding the basics of the RiO system into everyday practice and fathers were not routinely entered onto the system. Following the initial RiO training there had been confusion amongst some staff groups regarding access to existing mental health services RiO records in cases where such information could usefully inform Family Health Needs Assessments, particularly in regard to parenting capacity.

7.70 Whilst this has now been resolved, checking of the system would have revealed the fathers' previous history with CAMHS, but not his current mental health issues at that time. In fact, the SHV did check Rio but had not been provided with the date of birth for the father and did not therefore obtain any helpful information in any case.

7.71 Furthermore she was not advised to liaise with the midwife and GP to ascertain any relevant background information before visiting the family.

7.72 The SHV therefore believed this to be the couple's first child and they did not advise her otherwise. Her actions are then consistent with this belief. There is however ample evidence that she had identified them as vulnerable very quickly, and had offered a much higher level of visiting than the norm as a result. She also referred them to the Young Parents Champion[6] within 2 weeks of meeting them. This was good practice, in the absence of information to tell her that there were a number of high risk factors within the family.

7.73 SHV's Practice Teacher stated when interviewed by the IMR author that in her opinion the Bridgwater Health Visiting team at the time of this incident only received 60% of ante natal booking information and that relationships with the local midwifery teams were not robust with ongoing disagreement about how liaison information including booking information should be shared. A meeting between the midwifery team leader and health visitor team leader had made an agreement on how this would work with information being sent from the Eclipse system. The service commissioner at the learning event considered that this had been addressed. However discussion between the health visiting and midwifery participants made it clear that this was not the case and that confusion continued between practitioners about how this should happen. Clearly there is a learning point here about

[6] Somerset Partnership operates an enhanced sustainable care pathway for young parents which the midwifery service can refer into in the ante natal period. This service offers young parents increased levels of contact with a specially trained Young Parent Champion, focusing on a model of enhanced support delivered by the right person at the right time, providing effective signposting to resources and encouraging positive parenting roles

commissioners checking back with front line practitioners to understand how things work on the ground, and not just within written policy guidelines.

7.74 There was also a misunderstanding in the communication between the GP and the SHV which undermined effective safeguarding of Child Y.

7.75 As above, the SHV had received a telephone call from the GP who reported that when he saw Child Y the previous day due to oral thrush and nappy rash he was concerned about the father's rough handling of Child Y and his inappropriate language to the baby. The GP requested that this family receive a high level of support from the health visiting service. The SHV clearly documented this telephone call in the RiO electronic progress notes but did not clarify with the GP whether he had discussed his concerns regarding the handling of Child Y with the father and whether he had considered making a formal referral to Children's Social Care given the nature of his concerns. She also did not see the significance of this information as she had no context of parental history to heighten her awareness of risks and therefore did not consider sharing this information with Children's Social Care herself. She did however share it with HV1 who accompanied her on her visit to the family.

7.76 The issue of the GP contact with the health visitor also requires further consideration. The GP left a telephone message and then did not speak to the SHV until the next day. Delays of this nature are critical for such young babies. It would seem reasonable to expect that a GP would be aware of the high level of vulnerability of babies of this age and should have therefore considered the safeguarding implications and the need for a referral to children's social care, especially when he was unable to talk to a health visitor on the day that his concerns arose. As a minimum, the subsequent discussion with the student health visitor should have raised referral as a possibility. Instead he appears to have considered the family as being in need of support and that he had discharged his statutory duties by passing his concerns to the health visiting service. This was a missed opportunity to alert social care to the situation.

7.77 Unfortunately this error was compounded when both health visitors made the assumption that the GP must have talked to the father about his concerns as he was so gentle with the baby in front of them. They accepted this at face value and did not check either with the father or with the GP that this matter had been discussed. This was another missed opportunity to safeguard Child Y and further reflects the lack of background information held by them – awareness of which may have made them more robust in following up this issue.

7.78 In this vein of missed and misunderstood communication, the SHV did not consider the possibility of arranging an assessment with a Nurse Practitioner when she met the family in the Minor Injury Unit in spite of the father's expressed concerns about Child Y's health, the couple's relative parenting inexperience and Child Y's

increased vulnerability and susceptibility to infection due to his young age and immature immune system. Her inexperience meant that she did not think to check the father's story that they could not get a GP appointment.

7.79 The parents had placed the SHV in an impossible situation by turning up at very short notice in a clinic where she had no facilities. Her lack of experience also meant that she agreed to this arrangement and did not consider how suspicious this behaviour was. The SHV has learned from this experience not to attempt to examine a baby in their pram but rather to refer immediately to a clinician who is better placed to properly examine, diagnose and treat any problems in a baby of this age.

7.80 While it is clear from SHV's records and in subsequent interviews with her that she had correctly identified the family as "vulnerable" and in need of extra support, she had not translated the vulnerabilities into likely risk for Child Y. Given the very short time scale within which Child Y suffered injuries it is impossible to predict whether her practice would have changed to this focus in due course.

7.81 The SHV description of her first successful visit to the family in September 2013 is also worth noting. The SHV stated that this visit had been cut short because a rental officer had come to the door to offer the couple an opportunity to view a vacant flat which they had been waiting for. She described the father "jumping up and down with happiness" – child-like in his response to this news. This was why she had not been able to complete the Family Needs Assessment.

7.82 This 'child-like' behaviour was also described by the mother, who told the reviewer that the father had been "playing with Child Y and throwing Child Y up and down like a doll" when only a week old. This is highly concerning as it indicates a total lack of understanding about the vulnerability of tiny babies and may well have resulted in injury. This information has been shared with the police, and underlines the importance of early safety and handling advice to new parents.

7.83 No-one involved with the couple held all of the relevant information. This would have required multi-agency information sharing such as that required by the Unborn Baby Protocol or indeed by consideration of a Common Assessment, but at no point was it recognised that the couple met the threshold or criteria for either of these.

8. Lessons learned

8.1 As above, there are some very clear lessons learned and unfortunately they are not new and this is unlikely to be the last serious case review in which they are raised.

8.2 The Taunton and Somerset NHS Foundation Trust IMR states that "there was no direct individual failure to fulfil statutory safeguarding duties". Unfortunately I do

not agree with this conclusion, but I do acknowledge the difficult circumstances in which the GP and the midwives found themselves and the fact that their learning from this case means that those involved will never again make this kind of error.

8.3 The Trust has carried out an audit of practice in midwifery and identified a need to improve in: -

- Training and equipping midwives to recognise and act upon potential safeguarding concerns
- Training and equipping midwives to recognise and act upon domestic violence and abuse concerns
- Providing effective safeguarding supervision for midwives
- Communication between midwives and communication between midwives and health visitors.
- Monitoring and providing assurance relating to the above.

8.4 Specifically the Trust identified a number of issues with Trust Maternity Guidelines relating to domestic abuse in pregnancy and to teenage pregnancy. This includes the absence of timely review and inconsistencies in advice given.

- The Trust Domestic Abuse in Pregnancy guideline is out of date and does not accurately reflect/describe existing documentation (tracer card) used by the community midwives to record if/when the question about domestic abuse[7] has been asked.
- The Trust Maternity Teenage Pregnancy Guideline is unclear about the age parameters for teenage referral for Obstetric input and conflicts with another document, namely the “Request for Consultant Obstetrician Care/Advice referral form” used to request an appointment with a Consultant Obstetrician (the guidance states age 18 and the referral form states age 16). It also does not adequately define “learning difficulties” and or potential impact and/or action required. This caused confusion and inconsistent practice.
- Safeguarding Children training is mandatory for midwives. Reported compliance is very high (96%) and the midwives who provided antenatal care were in date with their attendance at Trust mandatory training. However the content of current safeguarding training for midwives was found to be not in line with current intercollegiate guidance (level 2 rather than 3).
- There is not a robust programme of domestic abuse training for midwives in place
- Practitioners need a greater awareness of the concept of respectful disbelief in domestic violence situations

8.5 The use of safeguarding supervision within midwifery was also not robust. The Trust has trained Safeguarding Supervisors and has Named Professionals whom midwives can access for safeguarding supervision. In the community setting

[7] The IMR and recommendations refer to ‘domestic violence’. I have changed this to ‘domestic violence and abuse’ in keeping with my recommendation at Section 9 of this report.

this was via the safeguarding midwife attending team meetings. However, the IMR has highlighted that if midwives did not attend team meetings or the monthly meeting was re-scheduled they generally did not access clinical supervision unless they were concerned about an unborn baby or young woman.

8.6 The IMR found no process for reviewing entire caseloads to provide a failsafe to ensure that child protection concerns had not been missed (as was the case in this instance). This would reduce the risk of safeguarding concerns not being identified (you cannot highlight what you don't recognize). In addition the investigation found that the monitoring process for safeguarding supervision was inadequate.

8.7 There is also room for considerable improvement in the communication between midwives and Health Visitors (HV) as there is currently no face to face communication between midwives about their shared caseloads and no process for handover of care.

8.8 Whilst a copy of the front of the Eclipse form was sent to HV at booking, there was no other engagement between the Health Visiting service and either the GP or midwifery service in the ante natal period. However the Somerset Partnership Foundation Trust states that at this time there were agreed processes in place across Somerset whereby booking information and any identified vulnerability factors would be shared with all relevant multi agency professionals including the relevant Health Visiting team by the midwifery team in a timely manner to ensure the pregnant mother was highlighted as a priority for an early intervention and support including ante natal Health Visitor assessment. A formal *Midwifery Communication Form* had been developed by the Somerset Maternity Services Liaison Committee, (MSLC), approximately two years previously, with agreement by Somerset Partnership NHS Foundation Trust, Taunton and Somerset NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust that it would be utilised by all health staff involved in ante natal care as the tool of choice for sharing risk and concern information. The form included "*teenage parent*", "*parental drug misuse*" and "*parental mental health issues*" as concerns to be communicated to other involved professionals including health visitors, GPs and Children's Social Care. The form should have been used as the mother was a teenage parent.

8.9 However, analysis of the "communication form" system indicates that it does not work well mainly because of two similar forms being in place. One is county wide and one Trust wide. Both contain similar but not identical information. The use of two forms has caused confusion and carries the risk of neither being completed as in this case. The county wide system is designed to promote information sharing (including concerns about potentially vulnerable cases, including teenage mothers) between midwives and health visitors.

8.10 Although there is an acknowledged expectation that health visitors and midwives should meet regularly to discuss caseloads and to highlight vulnerable

families, there are no standards relating to this. The investigation found no evidence of any formal meetings of this nature.

8.11 A recent audit provided to the LSCB and supported by ongoing internal audit does evidence that staff at the Trust do understand the pre-birth protocol. However, the investigation found that it was not implemented in this case as referral triggers were missed.

8.12 Somerset Partnership has a robust *Domestic Abuse Policy.* Clear communication processes are in place between the Trust and Avon and Somerset Police to share information about domestic abuse incidents where young children and/or pregnant women have been involved in the incident or are linked to it in some way. This information is shared with the Trust Safeguarding Children Nurses who in turn disseminates the information with the relevant health visitor or school nurse and reviews the incidents during planned child protection clinical supervision to ensure the correct actions have been taken that are protective to the children involved. In this case no such information had been received from the Police involving either the father or mother of Child Y as either victim or perpetrator in a domestic abuse incident.

8.13 Somerset Partnership NHS Foundation Trust also has a robust Child Protection system in place. The Trust *Safeguarding Children Policy and Procedure* is available to all staff on the Trust intranet and is reviewed annually. Regional policies and procedures for safeguarding children are regularly updated and easily accessible, (www.swcpp.org.uk).

8.14 As a qualified nurse SHV is accountable for her practice in her own right; however the supervising health visitor was also accountable for those cases she delegated to SHV and she should have ensured that there were robust arrangements in place to manage feedback of the outcomes of any contacts undertaken independently, relaying any factors of concern. SHV was clear that no such arrangements had been put in place to manage regular caseload feedback, reflection and discussion. This may have enabled her to identify the emerging risks in the case more quickly, although it is acknowledged that a very short period of time elapsed between allocation of the case and Child Y's injuries.

8.15 The RiO electronic record was introduced to the Somerset Partnership Health Visiting Service in November 2012 although it had previously been successfully utilised for a number of years within Somerset Partnership Mental Health Services. Amongst other actions RiO provides practitioners with the ability to "link" parents and children together; for example a child's record can contain a link to other family members providing this has been manually entered by the practitioner. This process relies on staff searching RiO to identify if the parents have already been registered onto RiO by other Somerset Partnership health services.

8.16 Initial RiO training for Health Visiting staff was provided in the Autumn of 2012. Staff were taught that in the ante natal period and early post natal period mothers and children were to be registered on RiO but fathers were not registered unless there was a specific health need or they had already been known to another service and this information had been shared with the health visitor. Where a Family Health Needs Assessment did not indicate any unmet health needs in relation to the father it would not be standard practice to either register them on RiO or review RiO to see if an existing Mental Health Services record existed for them.

8.17 At the time of this incident the Health Visiting service were still embedding the basics of the RiO system into everyday practice. Following the initial RiO training there had been confusion amongst some staff groups regarding access to existing mental health services RiO records in cases where such information could usefully inform Family Health Needs Assessments, particularly in regard to parenting capacity. However as staff became more competent with the RiO system and confidentiality issues were reviewed they identified that it was necessary to register all fathers and this remains the current practice within the Trust.

8.18 In this case SHV did not review the fathers' mental health RiO records, later stating that this had not occurred to her but if it had she would not have accessed them as she would have been concerned about a breach of confidentiality. The father's history in terms of his older children was recorded on RiO although the record had not been flagged to indicate a child protection issue although the flagging process is well known to RiO users.

8.19 The Somerset Partnership Health Visiting IMR states that the Service was not informed of the mother's pregnancy by either the GP or midwife, and that the first notification the service received was from Child Health when Child Y was born. However the community midwife service state that they were informed as are all pregnancies with a copy of the front page of the eclipse booking form. This system does not appear to have worked on this occasion and as a result there was no opportunity for an ante natal assessment to be carried out in the ante natal period by the Health Visiting service, missing a chance to identify the father's previous risk history. Clarification of this system is therefore required to ensure that no children fall 'through the net' in terms of early notification to the health visiting service.

8.20 What all of these issues amount to is a lack of pro-active vigilance and understanding in relation to the nature of risk to new born babies, compounded by systems which did not support such vigilance, and human error in believing the best of people. This can be translated as:

- The need to publicise the unborn baby protocol on the South West Safeguarding Procedures to all professionals, together with the research that underpins this protocol. It is of note that the number of hits onto this site prior to these events was minimal

- The importance of carefully recording concerns and of checking records at every point of contact with parents where some element of professional judgement is required about the potential vulnerabilities and risks associated with unborn and new babies

- The importance of early handling and safety advice for parents of new born babies

- That front line staff will be taken in by plausible and likeable characters and will want to believe the best of people, because we recruit caring people to the caring professions and it is difficult for them to be challenging of what people say. This is referred to as the rule of optimism[8] and is compounded in services which are not focussed on social risk factors. Midwifery services, for example, are primarily clinically focussed and not geared up for consideration of non-clinical risks in the same way that might be expected in other direct children's services. However, they play a crucial role, and this needs to be consistently addressed through focussed and reflective clinical safeguarding supervision that keeps these issues at the foreground of practice. The quality of safeguarding supervision and training needs to be continuously audited to ensure that it is fit for purpose to support them in this crucial function.

- Failures of communication and sharing of information are compounded by differing and complex record systems within the health community that do not talk to each other

- The importance of always following through on concerns expressed by colleagues and not making assumptions without doing so – checking back with the source of such concerns to ensure that they have been properly understood.

- The need to ensure that GPs are aware of the thresholds for referral to children's social care particularly in relation to new born infants, and to ensure that their expressed concerns are clearly understood and followed up

- The importance of professionals understanding the complex nature of domestic violence and abuse and the need to ask very specific and wide ranging questions about relationships in order to assist victims to recognise themselves as such.

- The need for clear and consistent transfer of cases and information between the midwifery and health visiting services, including the gathering and screening of information to identify potential risks prior to the allocation of health visiting resources to families with new born children.

[8] John Eeeklaar, Topsy Murray and Robert Dingwall: *The Protection of Children*.1983, later referenced by the NSPCC and introduced into social work literature through the 1990s and latterly the Daniel Pelka Serious Case Review

- The importance of identifying the role and impact of fathers on the ability of mothers to safely parent cannot be underestimated. GPs and other professionals need to share information about fathers where background or historical concerns exist, and to be advised when a male becomes known within the health service as a father.
- The use of the pre-CAF checklist would have assisted the midwives to identify the range of concerns and may have resulted in a CAF as a minimum, but this was not considered and needs to be better promoted as a tool to aid decision-making and information sharing across services with the permission of parents. Refusal to give permission would add to concerns and may then promote more proactive consideration of potential risks to children.

8.21 The Serious Case Review Panel also agreed that the model used for carrying out this review has been a positive one which has promoted learning for those involved in the case and has also brought a depth of understanding to the context of events which would otherwise have been lacking. The Panel recommends that the approach be adopted for future reviews.

9. Single Agency Recommendations

9.1 The single agency recommendations are taken from the IMRs and are listed below. However I additionally recommend the following:

9.1.2 Taunton and Somerset NHS Foundation Trust should positively consider the use of increased home rather than hospital or clinic visits for new born babies, particularly for teenage and vulnerable parents to assess how they are coping in the home environment and to ensure that safety and handling advice is understood.

9.1.3 Taunton and Somerset NHS Foundation Trust should consider how the CAF and pre-CAF checklist can be used in midwifery services to assist professionals in focussing on the assessment of social needs and risks associated with pregnancy and early parenthood.

9.1.4 Somerset Children's Social Care should ensure that all staff are aware of the implications of a further pregnancy where the parent has had a baby adopted already and should access the Unborn Baby Protocol or seek advice from the safeguarding manager.

9.1.5 All domestic incidents reported to the police regarding pregnant women should be shared with Children's Social Care, Midwifery and Health Visiting Services to enable them to be considered as part of a wider holistic assessment.

9.1.6 The discharge process for mothers and babies where there are concerns should consist of a verbal conversation between the midwifery and health

visiting professionals as a minimum standard. Answer phones should not be relied on to disseminate information regarding risk to babies.

9.1.7 Somerset CCG should ensure that all GPs are reminded of the processes for sharing key information about vulnerable women and children, for addressing concerns to parents where it is safe to do so and for making referrals to Children's Social Care when concerns have been identified. This should include the need for such referrals to be timely given the high level of vulnerability of infants to injury and poor outcomes.

9.2 Avon and Somerset Police

i. It is recommended that the protocol regarding unborn babies is re-circulated to all Public Protection Units (PPU's) and Safeguarding and Co-Ordination Units (SCU's) in order to act as a reminder of the necessity to share incidents of this nature to partner agencies and also to recognise the risk involved.

ii. This should also be disseminated to front-line uniformed officers who are often the first officers at the scene of these types of incidents.

9.3 Taunton and Somerset NHS Foundation Trust

i. Team leaders will monitor caseloads to ensure appropriate practice (in place – including retrospective review)

ii. All social risk assessments will be checked for completeness prior to discharge (in place)

iii. Briefing paper on Domestic Abuse to be circulated to all midwives (completed)

iv. Implementation of a system of face to face handover of shared caseloads between midwives (in place)

v. Implement and support a programme of Safeguarding training to allow all midwives to achieve level 3 competencies

vi. Pending the above, arrange and support attendance at a designated study day(s) for midwives to urgently increase their knowledge and understanding of Domestic Abuse

vii. Implement and support a robust system of safeguarding supervision for all midwives

viii. Update guideline on "Domestic Abuse in Pregnancy" (to include the adoption of a flowchart highlighting routine questioning about domestic violence, documentation of questioning, patient information, support agencies and referral process if the woman discloses)

ix. Revise Pregnant Teenager guideline and related Consultant Referral Pro-forma to have the same criteria for referral/s

x. Design and implement a Maternity specific Safeguarding flow chart as appendix to Trust Policy

xi. Design and implement a single cross-county electronic communication form

xii. Improve communication and collaborative working between midwifery and Health Visiting teams by regular meetings between the leads of these two services
xiii. Introduce a pilot programme of link professionals in midwifery teams run along the same lines as safeguarding link professionals in other clinical areas who provide peer support and supervision.

9.4 Somerset Partnership Foundation Trust

i. Somerset Partnership will provide formal feedback to all staff involved in this incident using the Significant Event Audit, (SEA), process to ensure staff will have learnt lessons from the incident with the aim of improving the quality and safety of services provided to vulnerable children and their families.
ii. Somerset Partnership will review the capacity of the Bridgwater Health Visiting team in terms of staffing levels and ensure there is parity of workload across the Health Visiting service.
iii. Somerset Partnership must work with its multi-agency partners to ensure current midwifery / Health Visiting liaison processes are reviewed and improved to ensure Health Visitors are informed of all pregnant women within appropriate time scales to allow timely and comprehensive ante natal assessments to be completed by Health Visitors
iv. Somerset Partnership will review the following elements of the student Health Visitor training experience to ensure current guidance is relevant and robust. This will include review of:
   - assessment of competence to practice processes
   - handover processes between taught and consolidated practice
   - access to regular and ad hoc clinical supervision provided by Practice Teachers
   - access to child protection clinical supervision provided by the Trust Safeguarding Children Team
   - allocation of relevant cases
   - the role and responsibilities of the Practice Mentor
v. Somerset Partnership will ensure that student Health Visitors are clear about their roles, responsibilities and limitations whilst undergoing the Health Visitor training programme within Somerset Partnership, particularly in relation to child protection and safeguarding casework
vi. Somerset Partnership will ensure that Health Visitor staff are updated on the correct use of the Family Health Needs Assessment process and the requirement to thoroughly assess parenting capacity and analyse the results in terms of likely risk to any children
vii. Somerset Partnership will ensure that local Health Visitor processes are reviewed and updated in relation to the assessment and management of risk, particularly those risks related to teenage parents

viii. Somerset Partnership will ensure that all the themes from this review are disseminated to relevant staff groups to ensure lessons are learned.

9.5 Children's Social Care

i. CSC pre-birth guidance should be updated to more explicitly highlight key risk factors associated with harm to babies.
ii. CSC guidance should consider amending it's pre-birth guidance to ensure that a Child and Family assessment is carried out on mandatory basis for all young parents who have spent time being looked after by the local authority, or have had children removed from their care previously.

9.6 Somerset Clinical Commissioning Group

i. Commend the team at Surgery1 for their flexible and inclusive approach to providing appointments for Child Y, and for the thorough examination and swift action taken
ii. Circulate the pre-birth protocol to all GPs, and incorporate this into GP Safeguarding Children education, with reminders to 'see the child behind the adult' as well as 'the adult behind the child', and to practice 'professional curiosity', including the importance of taking a social history when seeing pregnant women
iii. Emphasise the importance of reviewing the mental state and the compliance with medication for parents with mental health problems when they attend the surgery
iv. Review the management of domestic abuse presenting to Accident & Emergency departments
v. Ensure General Practices have clear policies on filing discharge summaries that include reference to domestic violence
vi. Review communication between Midwifery teams and GPs, ensuring that there is a clear process for information to be routinely shared in both directions
vii. Ask Somerset GP Educational Trust to provide a mental health study day for GPs, to include review and follow up of patients with mental health problems, and how to consider patients in their social and family setting

10. Recommendations for Somerset Safeguarding Children Board

1. The LSCB should promote and audit the use of the Unborn Baby Protocol and the accessibility of the on-line child protection procedures generally.
2. The LSCB should consider the development of multi-agency core safeguarding supervision quality standards and practice which can be audited on a regular basis.
3. The LSCB should consider the further promotion of domestic abuse training and in particular a focus on 'asking the difficult questions' to increase practitioner awareness and confidence in approaching potential victims about

this issue. The vulnerability of pregnant women and infants should be emphasised.

4. The LSCB should ensure the dissemination of learning from this review within its' learning and improvement framework:
    a. Locally via the Chief Executive Officers of member agencies, and the Safeguarding Adults Board, and
    b. Nationally, by sending a copy of this report to the Nursing and Midwifery Council and the Local Supervising Authority for NHS England to raise the profile of safeguarding in midwifery practice, and of domestic violence and abuse specifically.
5. The LSCB should require all partners to confirm that they are promoting the importance of the role and impact of fathers in their children's lives and that information about fathers is sought and shared to inform all work with families.
6. The LSCB should promote the use of the pre-CAF checklist and the CAF process for young parents.
7. The Chair of the LSCB should write to government to request that language in relation to domestic violence and abuse is common across all departments and in all publications and web-sites.

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