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

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1. Introduction

1.1 Child Y was just over three weeks old when Y suffered significant injuries whilst living at the home address and in the care of Y's parents, who were arrested on suspicion of causing Grievous Bodily Harm to the Child and faced prosecution. Child Y remains in the care of the Local Authority.

1.2. *Working Together to Safeguard Children 2013*[1] was the statutory guidance provided by government to Local Safeguarding Children Boards and their constituent agencies, at the time of this incident. This set out how agencies should work together. It stated 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."*[2]

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

1.4 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.

1.5 The review therefore examined the detailed accounts from professionals about what happened in order to understand whether there was any learning from this and to make recommendations for the SSCB as a result.

2 Terms of Reference

The review covered the period September 2012 – October 2013, but also referenced previous information where this was directly relevant to the circumstances of Child Y's life and injury.

The terms of reference were 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?*

[1] Now replaced by Working Together to Safeguard Children 2015

[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

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 fulfil statutory duties with regard to safeguarding in this case?*

3. How the Review was carried out

3.1 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.

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

3.3 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 fully met the criteria for independent reviewer.

3.4 Individual Management Reports (IMRs) were also requested from and provided by:

- Avon and Somerset Constabulary
- Somerset Children's Social Care
- Somerset Partnership NHS Foundation Trust
- Somerset Clinical Commissioning Group
- Taunton and Somerset NHS Foundation Trust

3.5 These reports were considered at the first Panel meeting in 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, Somerset County Council Children's Services

Named Midwife for Safeguarding, Great Western Hospital NHS Foundation Trust – commissioned by the SSCB 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 Police

Designated Nurse for Safeguarding Children and Children Looked After Somerset Clinical Commissioning Group (CCG)

Local Safeguarding Children Board (LSCB) Audit Officer, Somerset Safeguarding Children Board

Designated Doctor for Safeguarding, Somerset CCG

Safeguarding Administrator (taking notes) Somerset Safeguarding Children Board

3.6 This was followed by a development event for all of the practitioners involved 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.*

3.7 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 aspects of the case.

3.8 The reviewer and the Safeguarding Manager met with Child Y's mother. The father was also invited to a meeting on that day but did not attend.

3.9 The initial report was then considered by a further Panel 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.

3.10 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 and subsequently presented to the SSCB in September 2014.

3.11 This executive summary was subsequently produced in June 2015.

4. Race, religion and culture

4.1 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.

5. Summary of events

5.1 Child Y was born to young parents, the mother being only 17 years old at the time of her pregnancy, and just 18 when Child Y was born. The father was a former care leaver with many difficulties in his past life, and with 2 previous children with whom he no longer had contact. One of his children had very recently been placed for adoption at the point that Child Y was conceived. Unfortunately, Children's Social Care did not know that he was again about to become a father.

5.2 The mother of Child Y also had a difficult background, having parents who had separated and where there was domestic abuse and violence which had also affected her. This included an incident when she was 10 weeks pregnant when her parent slapped her face, and the police were called.

5.3 The couple shared some of this information when they had their first booking appointment with the midwifery services, and the father shared information that his previous child had been adopted. However, they presented as being very much in love and joyful about their impending parenthood, so the midwife did not think that there would be any risk to the Child and did not make a referral to children's social care.

5.4 The father's history was not then picked up at any point during the pregnancy or at the birth, and no alert was therefore in place when the case was referred into the health visiting service, and a student health visitor was allocated the case on the basis that these were first time parents. Whilst she quickly picked up that these were vulnerable young parents, and made a referral to the Young Parents Champion[3] she did not recognise that there may be risks to the Child.

5.5 When Child Y was 18 days old, the GP made a referral to the SHV as he was concerned about the father's rough handling of the Child and the way in which the father was talking to the Child during an appointment at the surgery. The SHV

[3] 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

followed this up the following day with a home visit, but she and her colleague were falsely reassured by the father's positive behaviour and tenderness towards Child Y on this visit.

5.6 The following day, the father contacted the GP surgery requesting an urgent appointment for Child Y, who was '*pale and sweating, coming straight down'* but did not turn up for this. Instead, he telephoned SHV and arranged to meet her at the local minor injury clinic, saying that he could not get an appointment at the surgery. The SHV saw Child Y in the buggy but did not examine the Child as Y was asleep.

5.7 The following day, father again contacted the GP surgery for an urgent appointment, stating that Child Y was pale, not taking as much milk as before and appeared to be shaking at times which he compared to an epileptic fit. He turned up with Child Y who was subsequently admitted to hospital with bleeding to the brain. Doctors diagnosed Non-Accidental Injuries consistent with more than one incident of shaking.

6. Lessons Learned

6.1 There were 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. In summary, the serious case review identified 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, together with human error in believing the best of people. This learning has been captured in the recommendations from the review and can be summarised as follows:

- The need to publicise the Unborn Baby Protocol on the South West Safeguarding Procedures website 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[4] 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;

- 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

[4] 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

parents. Refusal to give permission would add to concerns and may then promote more proactive consideration of potential risks to children.

6.2 The Serious Case Review Panel also agreed that the model used for carrying out this review had been a positive one which had promoted learning for those involved in the case and had 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.

7. Recommendations to Somerset Safeguarding Children Board

Many of the agencies involved in the serious case review made recommendations for changes within their own agency procedures and practice. However, I additionally recommend that Somerset Safeguarding Children Board should require the relevant agencies to report on the following:

7.1 Taunton and Somerset NHS Foundation Trust should:

- 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.
- 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.
- Ensure that the discharge process for mothers and babies where there are concerns consists 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.

7.2 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 Child adopted already and should access the Unborn Baby Protocol or seek advice from the safeguarding manager.

7.3 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.

7.4 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.

7.5 Somerset Safeguarding Children Board should also:

7.5.1 Promote and audit the use of the Unborn Baby Protocol and the accessibility of the on-line child protection procedures generally.

7.5.2 Consider the development of multi-agency core safeguarding supervision quality standards and practice which can be audited on a regular basis.

7.5.3 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.

7.5.4 Ensure the dissemination of learning from this review within its learning and improvement framework:

- Locally via the Chief Executive Officers of member agencies, and the Safeguarding Adults Board, and
- 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.

7.5.5 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.

7.5.6 Promote the use of the pre-CAF checklist and the CAF process for young parents.

7.5.7 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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