Derbyshire
Safeguarding Children
Board

Serious Case Review concerning Child A

Independent Author: Dr Russell Wate QPM

1.0 Purpose of the Serious Case Review and This Report

This Serious Case Review (SCR) concerns a baby who was only a few weeks old at the time they were taken to hospital with serious injuries. This was the third attendance at the hospital within a couple of weeks. The baby is referred to in this SCR as Child A. At the time of the serious incident Child A was living with mother, who for the purpose of this review is called AM. The father of Child A is referred to as AF and he lived mostly with AM living with her full-time following Child A's birth.

AM has a history of anxiety and low mood and has been treated with antidepressants in the past. AF has a history of early neglect and was adopted when he was very young. He has a criminal record dating back to his early childhood. He has disclosed difficulties with his anger and paranoia and has been seen by the Community Mental Health Team.

As the family were residing in Derbyshire during the timescales of this review, Derbyshire Safeguarding Children Board (DSCB) have completed this SCR.

As *"serious harm due to abuse or neglect of Child A is known or suspected*" the criteria in Working Together 2015 were met for the Local Safeguarding Children Board (LSCB) to undertake a Serious Case Review (SCR).

The period under review was agreed as from 1st March 2017 to 21st December 2017. Other information outside of the defined period was to be considered and included if identified as relevant or significant to the case.

2.0 Methodology

Chapter 4 of Working Together 2015 identifies the purpose of a Serious Case Review

The review author fully appreciates that during the review process Working Together 2018 was published. However, this review had already commenced and follows Working Together 2015 guidance, and the transitional arrangements for serious case reviews published in 2018.

Agencies with any relevant information or involvement with Child A and family were asked to provide an individual management review (IMR). They also provided a chronology. Analysis then took place and a learning event was held with panel members, IMR authors and practitioners. This was well attended and valuable contributions were made to this report. Using the information provided, an overview report was completed for sharing and developing with the SCR panel and then submission to the Derbyshire Safeguarding Children Board.

The Derbyshire Safeguarding Children Board and its constituent agencies began to address the recommendations at the end of this report as soon as it was completed. The Board (now the Derby and Derbyshire Safeguarding Children Partnership – DDSCP) has prepared a separate paper, setting out its actions and their impact, which should be read in conjunction with this report.

3.0 Analysis of significant safeguarding events (why things happened)

What follows in this section is a chronological summary, which is not intended as a priority analysis; that follows later and links with the recommendations.

Period prior to birth of Baby A

When the referral was made pre-birth, this case should have required further professional curiosity, so could have been screened as emerging needs, as it is believed by the review author that there was enough concern within the referral to undertake the triage within the complex needs' threshold.

It appears that the triaging social workers were overly optimistic and positive about AM and AF's situation from the initial discussions with AM. There is no evidence of curious questioning around the historical concerns, and vulnerabilities relating to both AF and AM.

There was a delay from the decision being made to the commencement of the assessment, by which time Child A had been born and was at home with the parents. This again led to an over optimistic view of how the parents would cope with a new-born baby.

It is not clear if the mention of learning difficulties in the letter to the GP following a mental health assessment in 2017 was understood by any of the professionals for example probation officers working with AF, as there is no code for learning difficulties in his GP notes, nor mention of the extent of his previous criminality. A referral was made to social care antenatally (during the pregnancy) regarding AM and her unborn child in relation to AM's past, but there is no outcome of the referral to social care in AM's notes. It is good practice that this information was shared at the primary care liaison meeting by the health visitor and any risk is noted in the records.

AF's difficulties with mental health were identified by practitioners on two occasions. At this time, AM was registered with another practice and so it would not have been easy to link AF with her pregnancy. There is no evidence that the GPs were curious to ask who AF's partner was and where he might be registered or living.

It is clear from the parents' health records that AM had suffered with anxiety and low mood and had been engaging with the practice regarding her mental health. AF's history is much more involved and complex.

It is positively noted by the review author within the IMR report from a health provider that they have recommended a review within their Trust of record keeping, documenting safeguarding information and how the reading and reviewing of scanned documents is recorded and is needed, to promote effective documentation, analysis and the sharing of safeguarding information.

This case highlighted some areas of positive practice by the Criminal Justice, Diversion and Liaison team (CJDLT). They are commissioned by NHS England and this service is delivered locally by a health provider[1]. AF was seen in a timely manner and attempts were made to get more detailed information from the referrer and the assessor. Staff understood the importance of 'think family' and were knowledgeable

[1] The team carries out screening to identify whether an individual has vulnerabilities. They will then support vulnerable individuals to access their first appointment and begin the process of giving them advice to improve their health outcomes and reduce their chances of re-offending.

regarding where to access support and advice and where to access the safeguarding policy. This engagement in this ante-natal stage, however, did not take into account or assess what risk AF would be to his partner. There is no information to indicate that probation (CRC) or CJDLT were aware that AM was pregnant, and should have assessed the risk to the mother and her baby, rather than just the risk to himself. It is fully accepted by the review author in the period much closer to the birth of Child A that a referral was submitted. The review author and the SCR panel also feels that there is not enough awareness of the work of the CJDLT in the local multi-agency safeguarding network.

A health provider's IMR highlights learning for them about the need to develop an understanding of possible child criminal exploitation and development of gang affiliations in young people who are alienated and vulnerable. This should help staff understand the context of the now adult behaviour and reduce the risks of judgemental language minimising needs and vulnerabilities. Fathers should always be considered as parents and as part of a 'think family' approach.

Information sharing would be greatly improved if alerts could be put in place across various health IT systems and ideally one local IT system would be of benefit across primary and secondary services with the facility to link service users by association, even if closed.

Period after the birth of Baby A

There are learning points that have already been acted on. For example, what happens now is that all unborn babies will have the full triage undertaken by a social worker. This will provide a robust approach with a better use of professional curiosity and suitable challenge from the social workers during the triage ahead of the final analysis of the information to determine the final decisions for further actions.

There was a lack of recognition at the start about the vulnerability of Child A. The medical and nursing staff did not challenge how a previous bruise or injury was sustained by a pre-mobile baby. The focus was on the medical illness due to bronchiolitis and Child A was not seen in the context of a possible non accidental injury in a pre-mobile baby, and therefore the opportunity to challenge further or discuss with a consultant was not carried out.

The documentation on Child A's first admission to the hospital has a description of the marks seen on the abdomen with a description of colour, size, location. AM's explaination of a dog scratch fits as a plausable explanation.

When Child A was subsequently re-admitted there was a missed opportunity to review the previous admission and therefore be aware that the previous attendance documented a bruise and to look at the evolution of the bruise and carry out any investigation. A full and detailed examination upon Child A's re-admission was not completed by the senior doctor, so the abdomen was not examined. When it was noted that there was a need to review this injury, there is no documented evidence that the consultant had taken into account that the appearance of the injury would have changed over a period of 5 days since it was first noted. What is not entirely

clear is the extent to which the child was examined, but the comment “rest unremarkable” was entered. The out of hours GP services communicated with the GP practice in the usual way with electronic summaries, as did the hospital. The review panel wondered whether this out of hours service was making any safeguarding referrals and asked for data. (This showed that over 3-month period five safeguarding referrals had been made.) The GP acted to ensure follow up was in place to review the mark seen by the hospital, but did not specify how urgently that review should occur. The GP in this case did not send in a safeguarding referral.

It has been identified from the review that there were missed opportunities to understand the evolution of the bruising to child A’s abdomen, arising from the apparent presenting condition (bronchiolitis) and oversight from senior medical staff could have been stronger to ensure that changes to the nature of the bruising (resolving) to a pre-mobile baby over a 5 day period were identified, recorded and acted on. This is crucial practice in recognising the vulnerability of pre-mobile babies and taking a holistic view and action on any unidentifiable/unexplained bruising. Learning has been captured and cascaded to Emergency Department (ED) safeguarding staff from this experience.

There was no documentation from the medical team that Child A was fit for discharge. This would be expected to be clearly recorded by the discharging medical team within the child's documentation. As there was no record regarding the discharge, there was a missed opportunity for medical staff to note the information recorded by the hospital named nurse for safeguarding children.

A discharge letter was completed and available for Child A, but a clear written plan for discharge was not documented, as required within the paediatric discharge policy. Had the paediatric consultant been made aware of the available information prior to discharge, it is possible that their level of concern would have been raised. It is unclear as to how the information received from the safeguarding team was shared. There was no evidence that it had been considered when ensuring a safe discharge for Child A.

It is fully acknowledged by the review author how challenging it is in general practice to link any parental issues to the child’s records, particularly those of the father, as they are often not residing at the same address. In this case, AF and Child A were residing at the same address but were registered at different practices for much of the time period that the review covered. The use of an alert on the child’s record is encouraged, if the mother or father is known by the GP or primary care practitioner to have significant mental illness or other illnesses, or lifestyle issues that might impact on parenting. From the records it seems that AM’s mental health was not thought to be impacting on her care of Child A.

Child A was only seen once during at the GP practice by a locum GP. There did not appear to be any concerns about the care of Child A raised during that consultation. It is not usual practice for a GP to access the parent’s records routinely at the time of seeing a child, unless perhaps there were a flag on the child’s records to indicate a specific concern regarding parental health. There was no such flag on Child A’s records

A GP did review the discharge summary that was sent out following Child A's admission just under two weeks later, which detailed the mark on Child A's abdomen and had requested that follow up was in place. Child A was also seen by the health visitor during the intervening time from discharge until the child protection medical and this entry was visible to the GP.

The health visiting service provided the universal healthy child programme to Child A and the parents and key contacts were completed within timescales. However, there were missed opportunities regarding enquiring about domestic abuse, meaning that pertinent information about the parents' relationship was not known.

Health visitor caseloads are structured to reflect the work that they complete with families which are 'universal', 'universal plus', 'universal partnership plus' and safeguarding. Child A and the parents were identified as requiring a universal level of health visiting service at the new baby review. However, as there had been a referral to Starting Point that had been allocated to the MAT and work was still being completed when Child A was born, the expected level of health visitor service at that time should have been universal partnership plus.

The health visitor service receives written information from hospitals, when children are either admitted or seen in hospital departments. As part of the information sharing pathway, these are put onto SystmOne (electronic child health record) and recorded as a scanned document. There was one discharge letter where the paediatrician had requested that the 'health visitor follow up in the community'. This letter was not on SystmOne until after the 6 to 8-week health review had been completed. It is not acknowledged in the health record that the scanned letter had been read or if there was any plan for follow up. Follow up was completed, but this was not reflected in the records and should have been as it was a direct request from the paediatrician. Further consideration needs to take place regarding how electronic scanned documents are acknowledged and noted to have been read by professionals.

There is evidence from the health visitor contacts that Child A had been observed to be thriving and responding to positive interaction from their parents, suggesting that Child A's needs were being met. This view did not take into account all of the other parental risk factors that were available at that time.

When cases are referred into Starting Point and information is requested from the health hub for a strategy meeting, the DCHS specialist health practitioner reviews the health information and discusses the case with their on call named nurse safeguarding children to enable advice and support from the named nurse, discussion of health information and to agree the level of threshold reached from the information known at the time. This did occur after the serious injury, and was timely and appropriate, allowing sufficient time for an in-depth discussion to take place prior to the strategy meeting, when it was agreed that the threshold for section 47 had been met. The following information sharing was then completed in accordance with guidance and is noted as good practice. However, there is no link to adult mental health or substance misuse services information accessible within Starting Point.

Domestic abuse was discussed in the strategy meeting and it was noted that the police had been out to AM's home for a domestic incident. AM was pregnant at this

time; however, enquiries by the review author with the police have confirmed that they did not know this information at the time of attending the incident.

The CJLD did try and engage with AF and attempted to work to help him with his mental health. However, when he disengaged, no letter was sent to the GP. There was also no information provided to this review as to whether they realised that AM was pregnant or that there was domestic abuse within the household.

4.0 Conclusions and Learning Themes

The above commentary and analysis show what happened during the period set for the review and at previous significant times. Conclusions have been made and there are some lessons to be learned in relation to the way safeguarding and promoting the welfare of children could improve.

The review author has recognised a number of themes for learning that have arisen from the analysis. These are:

- ***Pre-birth protocol not used***

The pre-birth protocol was not used or considered in this case. The triage of unborn babies at Starting Point is now undertaken by qualified social workers and decisions are signed off by managers.

- ***Lack of full agency checks and specialist risk assessments***

Professional curiosity when undertaking agency checks, particularly when the agency is an adult focused one, must be ensured. As well as guaranteeing that child focussed agencies consider and understand the potential/actual risk and impact of any information received about the child requires checking out with the other professional.

There were missed opportunities at the early help stage; there should have been more informative discussions during those early investigations and better questions asked when discussing the matter with probation and other agencies. The CRC (probation) said that AF was compliant with them, but the person spoken to was not a person that had actually met him. The question should have been not ‘is he at risk of re-offending’ but ‘is he a risk to the Child A and AM’.

A DASH risk assessment was completed by the police and AM was asked if she was pregnant. AM stated she was not. The risk and referral unit at the time enabled children services to review through a triage process all ‘standard’ risk DASH. There is and was in place at the time a pathway that any DASH where victim has children or states they are pregnant would automatically go to health and children’s services. So, if AM had said she was pregnant, this would have been referred.

The importance of reviewing all the information available in a thorough and structured way prior to hospital discharge is essential to ensure all the risks have been considered. Nurses should clearly document any marks or bruises seen on the ward and clearly communicate this to the paediatrician.

From the information gleaned from the GP records it would seem that there were some challenges in that, for the duration of the pregnancy, AM and AF were

registered at different practices. AM then registered with the same practice as AF along with Child A, after the birth. The learning to be taken from this is related to linking the difficulties and risks displayed by adults with their children, whether born or unborn.

- ***Allocation into correct case load for the Health Visiting Service did not occur***

There was a missed opportunity to review Child A's needs as part of the enhanced health visitor service, as Child A was not in the correct part of the health visitor caseload.

- ***Suspicious marks in pre-mobile babies***

Child A was seen in the context of a well-baby with bronchiolitis and not as a baby who had potentially sustained a non-accidental injury. There was a lack of professional curiosity around the initial bruise and injury and a willingness to accept that there were no safeguarding concerns, without any proper exploration, particularly an analysis of parental mental health history.

There were missed opportunities during Child A's two admissions in November to recognise a potential non-accidental injury and initiate further investigations and assessment.

AF the father of Child A was convicted and sentenced for the serious harm injuries inflicted on Child A. He was sentenced to a period of imprisonment.

5.0 Recommendations

The individual agency IMRs have identified recommendations and the DSCB should monitor the implementation of them. This Serious Case Review has identified learning and made some recommendations as detailed below and the implementation of these will assist the DSCB to deal more effectively with similar circumstances in the future resulting in the improved safety and welfare of children.

Recommendation 1

The DSCB should seek assurance from children's social care and their partners that the pre-birth protocol is operating effectively. An audit against this would be an appropriate method to provide this assurance. (The DSCB has already acted on this recommendation and completed the audit.) The DSCB should now take forward the findings of the audit, and the activity required as an outcome, to continue with improvements to the operation of the pre-birth protocol.

Recommendation 2

The DSCB should seek assurance from those services that deal predominately with adults that they take into account and fully understand, whether through a risk assessment or otherwise, the risk that the adult has to harm children. They should then share those risk assessments and concerns with the relevant partners.

Recommendation 3

The DSCB has in place a bruising in pre-mobile babies' policy, this now includes suspicious marks. The DSCB should seek assurance that this is being used effectively**.**

Recommendation 4

i) The DSCB should seek to ensure that all safeguarding learning, backed up by proactive guidance and/or policy, highlights to all mothers, fathers, and families about the vulnerability of babies.

ii) There is already in place locally a procedure for ensuring parents watch the DVD 'shaking the baby is just not the deal', which also ensures parents sign a confirmation form that they have seen it or at least a leaflet about it. The DSCB should request information on the impact that this campaign is having.

Recommendation 5

The DSCB to seek assurance from partners that they are asking about domestic abuse. They also need assurance that the current agreed pathway for domestic abuse notifications regarding pregnant women are being sent by all agencies to the 0-19 children's service.

Recommendation 6

The DSCB should ask DHCFT to circulate information to the safeguarding partnership, in relation to the work of the criminal justice and diversion team (CJDLT). There was at the SCR panel meeting a general lack of knowledge about this team.

Approved December 2020