



**Safeguarding
Children Board**

**CORNWALL AND ISLES OF SCILLY
SAFEGUARDING CHILDREN BOARD**

Child F- Serious Case Review

SCR REPORT

September 2016

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Contents

1. Introduction	3
2. Consideration for Review and Timescale	3
3. Summary of case	4
4. Parallel processes	4
5. Scope of Review	5
6. Methodology	5
7. Contributors to the review	7
8. Timeline	9
9. Appraisal and analysis	9
10. Findings and Questions for the LSCB	16
Appendix One – Acronyms and Glossary	20

1. Introduction

1.1 This serious case review concerns a four month old baby (Child F) who sustained a significant brain injury. Child F was brought into hospital by ambulance in June 2014 fitting and with bruising to the left buttock. Child F survived but has been left with a severe disability, which will be life-long. The injury sustained by Child F was subject to a police investigation, which culminated in Child F's father being charged. The matter was heard by the court in July 2016 resulting in Child F's father being found guilty of one count of child cruelty and being sentenced to 3 years custody.

2. Consideration for a Review and Timescale

2.1 This case was considered by the serious case review subgroup for the Cornwall and Isles of Scilly Safeguarding Children Board (CLOSSCB) on 30 July 2014.

2.2 The CLOSSCB Independent Chair made the decision that the circumstances of the child's injuries met the criteria for a serious case review, as set out in Regulation 5 of the Local Safeguarding Children Boards Regulations 2006. This requires the LSCB to undertake a serious case review in specified circumstances.

2.3 Regulation 5 (1) and (2) sets out the LSCB's function in relation to serious case reviews, namely: -

5 (1) (e) undertaking reviews of serious cases and advising the Authority and their Board members of lessons to be learned

(2) For the purposes of paragraph (1) (e) a serious case review is one where; -

- abuse or neglect of a child is known or suspected; and
- either- (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the Authority, their Board partners or other relevant persons have worked together to safeguard the child.

2.4 An independent lead reviewer was commissioned to conduct the review with a trainee reviewer and it was agreed to use systems methodology. The first meeting of the review team was on 10 November 2014. This was followed by five further meetings and also conversations with fifteen key frontline professionals bringing the review to June 2015. There was then a pause in the process for the criminal investigation, as the police were awaiting medical reports from a number of specialists.

2.5 The police eventually made the decision to charge the father in November 2015. The first court hearing was 17 December 2015. Following the police decision not to charge the mother it became possible to involve her in the review, along with other family members and the foster carers as the mother was a care leaver. The review team meeting to consider the first draft pre-trial report was on 18 November 2015. The police further advised on 15 January 2016 that a not guilty plea had been entered and that the matter would be

going to a full trial in July 2016. This is the reason for the delay in publishing the report of the serious case review.

3. Summary of case

3.1 The family composition is set out below and pseudonyms are used in the main body of this report to protect the identity of the individuals:

Child F

Mother

Father

Paternal Grandmother

Maternal Sister

3.2 Child F was brought to the Accident and Emergency Department in June 2014 seriously unwell and fitting. The explanation from his parents was that he had been in the care of his Father during the evening and into the early hours while his Mother was out with friends. Child F's Mother had planned to be out overnight but came home early at 2.00 am to find the baby was clearly not well, "staring and twitching". Mother tried to settle him for some hours and then called 111 at 07.41 am and informed the service that her baby had been waking up screaming all night. As well as staring and twitching, she said he would not take his bottle. His breathing was described as heavy and his head floppy. The 111 team deemed this a medical emergency and an ambulance arrived at 07.53 am. The audio recording of this call to 111 has been heard. The baby is heard in the background in obvious distress with grunting respirations. He was taken to the nearest hospital Emergency Department arriving at 08.22 am. He was still fitting and noted to be pale. He was found to have bilateral brain haemorrhages and bruising to his left buttock.

3.3 Examination revealed injuries considered to be non-accidental. He was stabilised but then urgently transferred to a specialist unit in Bristol by Air Ambulance. He remained in a specialist unit for some months. Currently he no longer requires in-patient hospital care and is being cared for by his Mother with the support of a number of professionals to meet his various needs. He has been left with a significant disability as a result of his brain injury, the real extent of which will become clearer as he develops and grows.

4. Parallel Processes

4.1 An initial strategy discussion was held after Child F was taken to Accident and Emergency involving police, health and social workers. Steps were put in place to prevent either parent having unsupervised access or contact with him while a police investigation commenced.

4.2 The police investigation took longer than normal to complete as numerous medical expert opinions were required from appropriate specialists. The police investigation needed to consider any potential issues of neglect as well as ascertaining the possible perpetrators of the injuries and to ascertain if there were any historic injuries to be detected.

4.3 This review was not completed within six months, which is the preferred timetable for serious case reviews, due to the on-going police investigation which took primacy. The police investigation was dependent upon receiving medical evidence which is not unusual for cases of this nature and can be complex in establishing the facts and securing clear expert evidence. It was agreed that the review could include the involvement of Mother and other family members and this took place in November 2015. This was done within strict parameters around what could and could not be discussed so as not to prejudice the police investigation and potential criminal proceedings.

5. Scope of the Review

5.1 At the start of the case the review was scoped and terms of reference agreed.

5.2 The focus of serious case reviews is on how safeguarding systems and practices within the agencies operate together to safeguard the child. The review did not go back in history because systems have changed over time. This does not mean that family history and contextual information is overlooked but what is relevant is whether the professionals working with the family during the period under review knew about the family history, whether information was shared effectively and whether the system in which they operate supports working together effectively.

5.3 It was agreed that the main focus of this review would be the events from Child F's birth to the point of his admission to hospital in June 2014 and how professionals worked together to identify and reduce any risks to his welfare.

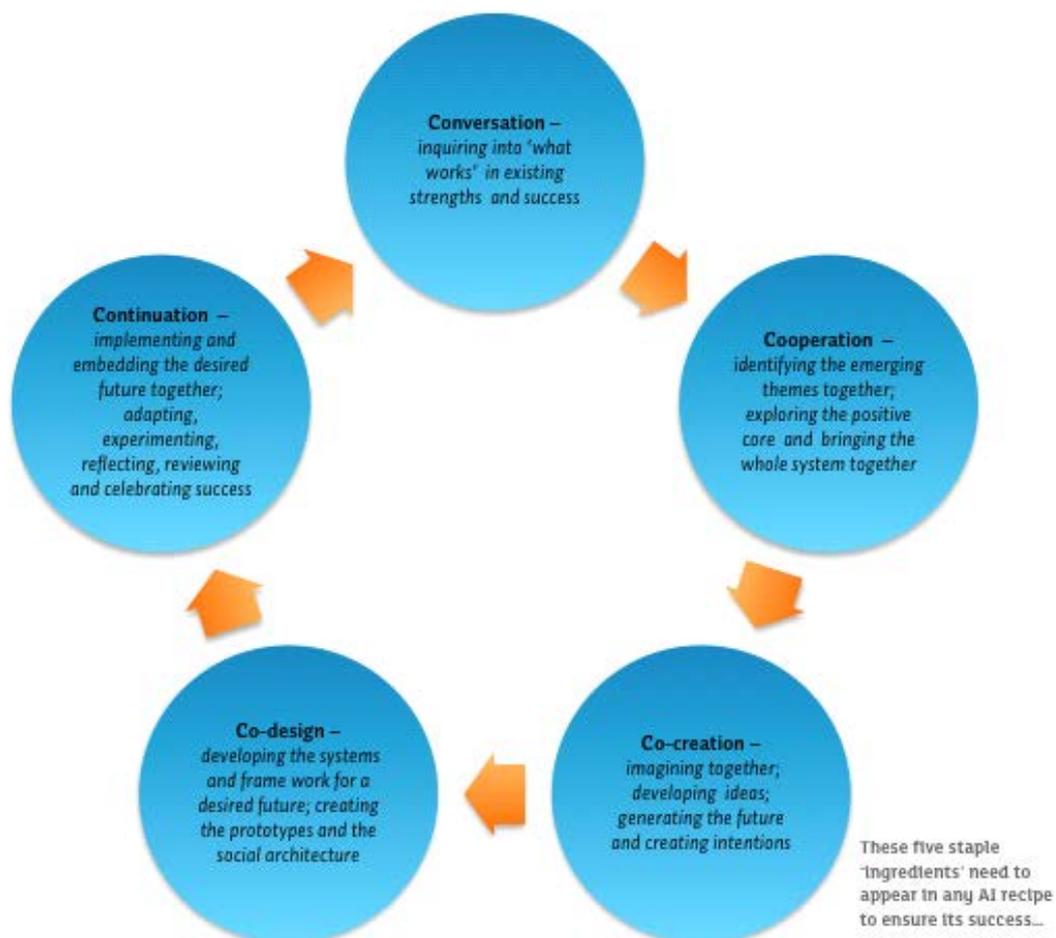
6. Methodology

6.1 Working Together states LSCBs may use any learning model which is consistent with the principles within the guidance, including systems methodology.

6.2 The Department for Education has set aside a proscribed model procedure in favour of the principle of learning. This allows local safeguarding children boards (LSCBs) and reviewers more freedom to explore what happened, whether any weaknesses can be identified and rectified, with the aim of preventing tragedies like this. Any application of the principles will be considered by the Department for Education to be consistent with systems methodology.

6.3 The systems methodology and appreciative inquiry was the agreed approach of the LSCB for this review. The review has been approached with the five principles of appreciative inquiry in mind. See below.

THE FIVE AI ELEMENTS



6.4 The LSCB identified that this serious case review held the potential to shed light on particular areas of practice.

6.5 The main statutory and non-statutory guidance to protect and safeguard children is contained within: -

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children. March 2013 (now revised to 2015).

6.6 In Chapter 4: "Learning and improvement framework" there is a set of principles which LSCBs should apply to **all** reviews, including serious case reviews.) These are: -

- 'A culture of continuous learning and improvement across the organisations that work together...;
- The approach taken to reviews should be proportionate...;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews...;
- Final reports of SCR's must be published... The impact of SCRs...must also be described in LSCB annual reports and will inform inspections; and
- Improvement must be sustained through regular monitoring and follow up...'

6.7 SCRs and other case reviews should be conducted in such a way which:

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

7. Contributors to the Review

7.1 The review team consisted of a senior manager from each of the agencies involved during the period under review, none of whom had had line management of the case, and two independent reviewers.

7.2 The review team consists of: -

Deborah Jeremiah, Lead Reviewer
 Lorraine Bateman, Trainee Reviewer
 Principal Officer, Child and Adult Protection
 Designated Doctor, Hospital
 Supervisor, Family Nurse Partnership
 Principal Officer, Child Protection
 Service Manager, Multi-Agency Referral Unit
 Team Manager, Child Protection
 Principal Social Worker
 Named Nurse, Hospital
 Senior Service Manager and Professional Lead for Health Visiting and School Nursing
 Detective Sergeant, Public Protection Unit
 GP, Primary care

7.3 The Ambulance Service did not join the review team as they considered their involvement minimal. This did not limit the review in any way. The Housing Service provided information into the review across two local authority areas.

7.4 The engagement of the review team was positive. The lead reviewers are grateful to those review team members who maintained their engagement and attendance for review meetings throughout the process. The lead reviewers would also thank the safeguarding administrator who supported the review throughout in an excellent and efficient manner.

7.5 The case group was made up of the key frontline professionals who had been working most closely with the family during the period under review. Seven professionals contributed directly to the group and additional conversations were held with another eight professionals. This provided a rich source of information as to what was known about the family at the time and also to understand the rationale of decision making around the family and unborn and born child in a system context. Those contributing from this group included:

- Police officers
- Midwives - from both counties providing antenatal and postnatal care
- Health service safeguarding leads
- Personal Assistant (Leaving Care Service)
- The manager of the Multi-Agency Referral Unit (MARU)
- Health Visitor
- Junior and senior doctors who attended Child F at both hospital admissions prior to the serious injuries being sustained

7.6 There was ongoing interaction between the two groups to test out accuracy, developing analysis and findings.

7.7 Documents considered for the review include:

- Integrated chronology
- Conversation notes
- Hospital medical records including discharge summaries (n.b. some records were lost)
- GP summary records
- Housing records
- Care leaving documentation and pathway plan
- NICE Guidance re antenatal care standards
- Transcripts and audio of all 111 calls
- Personal assistant records and supervision records
- Head circumference measurements and centile information from the Red Book (handheld child's medical record)
- Safeguarding policies and pre-birth assessment criteria
- MARU referral and protocols
- South West Safeguarding Procedures including escalation policy.
- Care Leavers Legislation
- "Staying Put" guidance HM Government
- Relevant previous SCR's

7.8 The involvement of family members in serious case reviews gives a helpful perspective that can provide a rich source of learning. Child F's Mother and Maternal Sister were helpful in contributing to the review and the review team were grateful for the time all family members gave in meeting with the lead reviewers and report author and providing their important perspectives.

7.9 Father's family understandably declined to contribute to the review and as a result of the police investigation it was not appropriate to approach Father to participate in the review. This review is limited by the lack of his perspective and contribution. As a result we do not know what support or service needs he may have needed from the time he knew he was going to be a Father and in the context of his relationship with Mother before and after his child was born.

8. Timeline

8.1. Set out below is a timeline of key points on the story of the child and family. This is not an exhaustive chronology but a timeline in keeping with systems methodology. This is taken from an integrated chronology prepared for the review by the agencies involved with the family.

8.2 The identification key for the professionals is as follows:-

- Personal Advisor, Social Care 16+ Team – PA
- Health Visitor – HV
- First Community Midwife - MW1
- Second Community Midwife - MW2
- Third Community Midwife - MW3
- Safeguarding Midwife, Cornwall - MW4
- Safeguarding Midwife, Plymouth - MW5
- General Practitioner – GP
- Multi Agency Referral Unit - MARU

8.3 There is a glossary at **Appendix 1**

9. Appraisal and Analysis

9.1 Statutory guidance requires that serious case reviews provide an analysis of what happened in the case and why, and what needs to happen in order to reduce the risk of recurrence. These processes should be transparent, with the findings of the review shared publicly. The findings are not only important for the professionals involved locally in cases. Everyone has an interest in understanding both what works well and also why things can go wrong and what can be done to improve the safeguarding systems and practice.

9.2 In February 2012, Mother moved from a long term foster placement (previously subject to a Care Order) to an open door semi-independent living placement. This meant a change in the key professional supporting her at this time, from a Social Worker to a Personal Assistant (PA) as the Post 16 Service became involved. The 16+ Service is a partnership between the Local Authority and Action for Children. The Service works in accordance with the statutory duties under the Children (Leaving Care) Act 2000. Open Door is an established supported lodging scheme for care leavers aged 16+ to help prepare them for

independence. The PA becomes the key worker for advice and support. The PA is not a qualified social worker but has had training for this role and was experienced in supporting care leavers making the transition to independence.

9.3 Mother informed her PA she was 9 weeks pregnant in July 2013. On this day Mother also saw a midwife (MW1). MW1 thought Mother had a Social Worker and she advised Mother to ensure her Social Worker was aware of her pregnancy. The midwife knew that Mother was a care leaver but was not familiar with the care pathway for care leavers or the role of PAs. This was because she did not encounter care leavers in transition that often and also there was nothing in her training and experience to inform her that the PA is not a qualified social worker. **[Finding One]**

9.4 Child F was born on 25 February 2014. At the point of discharge the midwife completes a form that addresses the medical fitness to be discharged rather than any social circumstances. There were no concerns at this time. The midwife discharging Mother had no knowledge of the involvement of the PA or of the role of the PA in supporting care leavers.

9.5 On 27 February 2014 MW3 visited Child F and Mother at home on day 2 after the birth. MW3 recalled Mother was worried about the baby's breathing and she gave reassurance that his respiration and temperature appeared normal but that if Mother continued to be worried she could see the GP. MW3 gave the relevant contact numbers. Father was present on this occasion but did not involve himself in the appointment. MW3 said that she, "never got much from him" and "he didn't seem interested". She said, however, there was nothing in the interaction between him and Mother to concern her. MW3 did not observe him with the baby. No observation was made of Father's parenting or attachment although this should apply to both parents. All the professionals and review team accepted that culturally there is still a tendency for professionals to focus on mothers and not to pay sufficient attention to fathers. **[Finding Three]**

9.6 MW3 visited again on 28 February 2014 (Day 3) which is normal practice for a first baby. Child F was weighed and had lost a little weight in line with expectations. He was a little jaundiced but MW3 was happy with progress. She does not recall anything about his head size. MW3 was led to believe that the Parental Grandmother (PGM) was offering support at this time and got the sense she may have been promoting breast feeding. The next contact was on 2 March 2014, (day 5) when Mother and Child F were seen by a different midwife.

9.7 On 4 March 2014, (Day 7) Mother and Child F were seen again by MW3. This appointment is likely to have been arranged because of the move from bottle to breast feeding. MW3 weighed Child F who had not lost weight. He had good skin tone and yellow stools so "all normal". There is no recollection of concerns around head size. The last visit by MW3 was on 10 March 2014, (Day 13) and MW3 discharged Mother. MW3 had no concerns. That was the last contact MW3 had with Mother and Child F. MW3 was not aware that Child F was also being seen by the GP (27/02/14 and 10/03/14) and MW3 had not had any direct contact with the GP. For this review the GP stated that communication with the health visitors tended to be stronger but even that interface, in their view, had been weakened when health visitors had moved out of GP surgeries and were managed separately following changes in NHS organisation.

9.8 For Mother and Child F their experience of guidance and support provided through health practitioners proved more complex, due to a number of changes of address and a resulting delay in their health notes being transferred. When a baby is delivered the hospital will notify the health visitors who will also provide support in the post-natal period. As Mother had remained with the GP in the other county she was unknown to the health visitors in the area to which she moved after leaving Father's family home. There was no previous information other than that provided by the hospital when Mother and Child F were discharged. This contains basic information around the clinical aspect of the birth and physical checks done on the baby at birth. The head circumference is taken at birth and Child F's head size was within normal parameters.

9.9 The first visit by the HV was made to Child F at home on 11 March 2014 (14 days old). The HV's expectation at this point would be that the midwife would have weighed the baby at day 3-5 and done blood screening. The baby's head circumference is often done by the HV at this visit. The HV did not take this measurement on this occasion as he was asleep. Mother was friendly and welcoming and was on her own. The accommodation was appropriate and noted to be warm and clean. During the visit they discussed the birth and throughout Mother presented as mature and positive. Child F was described as settled and feeding well. There were no concerns that warranted liaison with Mother's PA.

9.10 Mother informed the HV that Paternal Grandmother was supportive and she had stayed with them for a few days following discharge from hospital. Mother said that her own brother and sister lived locally and were also supportive.

9.11 The HV made an appointment for Mother to attend clinic with her baby on 25 March 2014. The HV wrote in the clinic book that the baby required weights and measures to be done, so her colleagues would see it. There was nothing of any note recorded about his head circumference. Mother was unable to attend the clinic on 25/03/14 and the HV followed it up with a call to her on 28/03/14. Mother apologised and a further clinic appointment was made.

9.12 On 1 April 2014 (at 5 weeks old) Mother and Child F attended the clinic where they saw a nursery nurse and weights and measures were taken and found to be normal. These will have been recorded in the red book if the parent has it with them. These are not always plotted on the centile chart. The Mother's PA visited her at home on the same day.

9.13 The HV received a notification that Child F had attended the hospital with Mother on 8 June 2014 and that he was discharged on the same day with gastroenteritis. The HV was not sure when she first saw this notification.

9.14 The HV said she was later alerted to another notification of a hospital admission on 11/06/14 (discharge on 13/06/14) where Child F had similar symptoms to admission on 8 June 2014. The HV said she rang Mother to ask how things were, given that there had been two hospital admissions, which may have suggested something may not be right. The HV had a follow-up telephone conversation with Mother on 23 June 2014, which is regarded as good practice and Mother described that her baby had been unwell but was now better, "back

to himself and feeding better". Mother said she felt that she was not listened to or her concerns taken seriously in the hospital. Mother told the HV about the diagnosis of a heart murmur.

9.15 The HV acknowledged a delay in notifications being available in the child's records to the health visiting team, for example from any hospital admissions, as these can sometimes take 2 weeks to arrive/be uploaded and are not date stamped to show arrival date. The HV describes communication with colleagues within the team as effective but largely informal. There is no formal mechanism for transfer of information from midwife to health visitor or from GP to HV. The HV's have "open door" access to the GPs so if they need to talk they will wait outside the GPs door until there is a gap in patients. This process relies on one seeking out the other, area based knowledge and the quality of working relationships and informal contact. These arrangements do not appear to work so well across larger areas or across health area borders. [**Finding Two**]

9.16 In contributing to this review, Mother reported that the immediate postnatal period was difficult. She describes feeling low about Father not helping and not wanting to be a dad. He liked living with his mum and dad and watching television and doing what he wanted and she described the relationship as not working. If she asked him to watch the baby while she did the washing up, she said she would come in and he would sometimes be asleep on the sofa. She felt that Father was jealous of the baby getting attention. She felt she was doing everything and he would rather just go out with his friends. They did come to an agreement that Father would have the baby regularly, on a Wednesday and Saturday, so that she could go out with her friends and on those days he would stop over with the baby in Mother's flat. Mother made the decision to co-parent with Father but to end their relationship. Mother and Father were initially supported by the Paternal Grandparents in the first few weeks. Mother said she was close to her own brother and sister but didn't see them that often. She said she was also seeing less of Father's parents after the first few weeks. It is important to repeat that it has not been possible to ascertain Father's perspective about becoming a parent, his relationship with Mother and his experience of services. So the review is limited in this respect.

9.17 Before being taken to the hospital with a serious brain injury on 30 June 2014, Child F had had two previous admissions to hospital that month as Mother felt there was something wrong with him, also expressing concerns about the size of his head circumference on the second occasion he was seen in the hospital. In both cases he was examined thoroughly, diagnosed with gastroenteritis, assessed as having improved and he was discharged home to the care of his parents. There were no concerns recorded that warranted a referral to children's social care.

9.18 **First hospital admission.** On 8 June 2014 Child F was seen at hospital. This is the first time that indicates that Mother felt all was not well with her baby and led to concerns about his physical health. He had had his second immunisations some days previously having had his first on 30 April at the same time as his eight week check. On 30 April his head circumference was 43.5cm against a measurement of 36cm at birth and 39.5cm on 1 April. A further measurement had been done on 10 March but not recorded.

9.19 Mother called 111 at 8.32 am on 8 June 2014 and said that her baby was crying inconsolably. She described coming home late at night (7 going into 8 June) and he was screaming and vomiting. Father had been caring for him as she had a night out as they had agreed between them. The 111 records state that Mother reported that her baby had been vomiting and screaming all night. The baby was not limp, floppy or unresponsive but Mother described "red veins" on his head that were "lumpy" to touch. His vomit was milk coloured and he had been distressed all night and he appeared to be in pain. It is recorded that Mother was very upset as the baby had not stopped crying. Mother was advised to take her baby to the GP within two hours. In the meantime she was advised that if he had breathing problems, became limp, floppy, and unresponsive, had new marks like bruising or bleeding under the skin or if he had a fit that she must ring 999 immediately. He was subsequently admitted to hospital on 8 June but discharged later that day.

9.20 Mother felt that her baby had started to become unwell after his second immunisations which were administered on 3 June 2014. She had noted blood in his nappy and the GP said this was a side effect of the injections. Mother had been out with friends on 7 June 2014 going into the early hours of the 8 June 2014 and when she came back there was lots of baby vomit on the floor and she noticed a mark on his head, "like a bruise" (this was the term that Mother first used). She took advice from her Maternal Sister, who was training to be a nurse, and then took the baby to the GP after speaking to the 111 service the next morning.

9.21 The GP sent Child F to the hospital and he was admitted to the assessment ward and was seen by a Consultant Paediatrician. This doctor concluded the marks on the baby's head were likely to have been self-inflicted from the baby's nails scratching his head. The Consultant conducted a thorough examination and nothing else was noted and Child F had settled well. The head circumference was not measured nor other investigations undertaken as the marks were considered to be self-inflicted scratches. Child F was observed to be touching his head in that area and scratching there on numerous occasions with local inflammation and redness and some minor discoloration. Child F was later discharged having been observed to settle. The possibility of non-accidental injury was considered by the Consultant Paediatrician and discounted as it was considered that Child F had a gastric infection and had settled in hospital. Mother told the review that she did not challenge this discharge.

9.22 Mother made further calls to 111 on 9 June 2014 (11.13 am and 11.49 am) and the advice given was to take Child F to the GP. Child F was seen in the urgent clinic at 2.15 pm and it was noted that he has been vomiting on and off but had no diarrhoea. The GP examined the baby and he was well hydrated and alert and his skin tone and fontanelle were noted as normal. The fontanelle is an important indicator of the health of a young baby. The GP concluded that Child F had a viral illness and gave advice to Mother around keeping up fluids and to come back if anything changed.

9.23 **Second hospital admission.** Father rang 111 at 4.09 am on 11 June expressing concerns that Child F was unwell and "not right". Father told 111 that the baby had been vomiting, crying and unsettled for three nights, seemed in pain and was crying inconsolably and was hot to touch. The advice was to

take the child to the GP and advice was given around administering medication to reduce the child's temperature and pain. Child F was brought into the GP by Mother mid-morning and was seen by a different GP. This GP was concerned as in his view Child F was "not handling properly, was floppy and not right".

9.24 The GP referred Child F to the Paediatric Service. The GP describes no problem with that referral, which was immediate and reflected good communication. In hospital Child F's head circumference raised concern and the admitting nurse found Child F to be irritable and floppy and Mother reported he had been like that for the last few days. The nurse also noted that he seemed to be in pain on handling and that when taking his blood pressure she noted his left eye was deviated towards his nose while his right eye stayed midline. His head circumference was noted to be on the 99th Centile at 44cms and his head looked large in proportion to his body. Mother told the nurse that she had noticed his head was getting larger for some time.

9.25 On further assessment by Ophthalmology there was no sign of optical damage or abnormality and the doctors concluded that Child F had a viral illness. There were no neurological problems and Child F improved in hospital. The Consultant saw Child F on 12 June and noted the results and on a thorough examination a heart murmur was detected, which led to a referral for a cardiology assessment. The heart murmur was seen as not serious and was addressed through an out-patient appointment. Child F's other symptoms were reducing and professionals were reassured that the ophthalmology report showed no abnormalities.

9.26 Mother became tearful when she was told that her baby would be discharged and she maintained he was not right. She felt there was something more serious than a viral illness and as a result he was kept in another night for observation. The doctor's reflection in this review is that the news that Child F had a heart murmur seemed to shock and worry Mother and she was anxious as to what that might mean. The doctors reassured her that this was not an uncommon occurrence and that Child F would be assessed by a heart specialist who would advise further.

9.27 It was not entirely clear to professionals what was causing his head circumference to increase and it was difficult to accurately see the head circumference in relation to the birth and other measurements as the relevant records were not readily accessible. Child F had records in several places; birth records, GP records, health visitor records, and historic hospital records, in addition to the Red Book, which is a record held by parents. For this review the Consultant explained that a number of conditions can cause the head circumference to increase and it was difficult to have a clear picture or plot the increase over time. As Child F was settling and was well he wanted to bring him back into clinic and measure his head circumference again. He stated that there was no evidence or indicators to suggest that Child F had sustained any trauma to the brain at that time.

9.28 For this review the doctor explained that a large head circumference does raise questions and he would be thinking of several possible causes and scenarios including non-accidental injury. Had there been any brain trauma or head injury they would have expected to see other bruising marks, for example

changes in the fontanelle and changes in the back of the eyes indicating bleeding. The Consultant saw Child F at the clinic who was well and behaving normally for a baby of his age. The doctor suggested he would like the head circumference to be monitored by the HV and this request was communicated to the GP, HV and the supervising consultant. Mother and Father were observed to be interacting with Child F and each other appropriately during this hospital admission.

9.29 Prior to the outpatient appointment Mother and Child F were seen at the baby clinic for baby massage and although a formal assessment was not made, as this is a drop in clinic for baby massage, he was seen to be well. Mother also told the HV on 23 June that Child F was back to himself but criticised the hospital, which she considered did not take her concerns seriously.

9.30 **Outpatient appointment.** Mother and Father attended the Outpatient appointment at the fast track clinic on 27 June, which is a clinic for children up to the age of 16 who require a swift appointment. The rationale for this appointment was to check the head circumference and general health of Child F. When the parents arrived it was clear that they thought the appointment was for the heart murmur but the doctor explained that the appointment for that would be on 1 July. The doctor observed Mother to be anxious about that and needing reassurance. The parents had forgotten the Red Book where earlier head circumferences would have been plotted and the doctor had the previous admission records before him. Both parents were happy that their baby was much better, and back to his normal self and all developmental checks were normal. The baby was examined and he was smiling and fixing on objects visually which was considered normal. His head circumference was in line with the last measurement and his head looked normal to the health practitioners. There was nothing to note of concern and he was discharged with a request that the HV keep an eye on head circumference.

9.31 **Third hospital admission.** At some point between 28/29 June 2014 Child F became seriously unwell and was subsequently admitted to hospital with significant injuries to his brain and bruising to his left buttock.

9.32 The account given was that he had been in the care of his Father during the evening while Mother was out with friends. Mother returned home at around 2.00 am to find the baby was clearly unwell and 'twitching'. She tried to settle him and then eventually called 111 at 07.41 am and informed the service that her baby had been waking up screaming all night and was described as "staring and twitching" and would not take his bottle. His breathing was described as heavy and his head floppy. 111 assessed this as a medical emergency and an ambulance arrived at 07.53 am. Child F was taken to a hospital Emergency Department arriving at 08.22 am. Child F was still fitting and noted to be pale. The medical examination found he had bilateral brain haemorrhages and bruising to his left buttock. These were considered to be non-accidental injuries. These injuries and the circumstances surrounding them became the subject of a police investigation and medical expert opinion.

10. Findings

10.1 The review team concluded that it would not have been possible to have foreseen the actions taken by Father on the night he injured Child F. The review team acknowledged that there was neither indication of nor concern from a range of professionals who saw Child F, about neglect or abuse until the hospital admission and medical examination on 29 June 2014 and there was no cause for concern previously that warranted a referral to be made for either support as a child in need or safeguarding. The review has identified general learning for agencies which is detailed below.

10.2 The review team has identified three findings for the Cornwall and Isles of Scilly Safeguarding Children Board to consider, which are summarised and then explored further individually in reference to the appraisal and analysis. Finally, each finding raises questions for the Board to consider in accordance with systems methodology. The LSCB is then free to deliberate and decide within the learning what, if any, they consider are priorities for improving the safeguarding system and practice in order to do everything possible to prevent a recurrence of this form of harm.

FINDING ONE -The role and responsibilities of a PA in supporting care leavers is not consistently understood across agencies indicating a need for all agencies to consider incorporating this into single agency training.

FINDING TWO - The fragmented health record systems do not ensure timely and reliable information sharing, which is at the core of an effective safeguarding system

FINDING THREE - Fathers appear to continue to be of secondary or sometimes given little or no consideration by professionals

10.3 Finding One: The role and responsibilities of a PA in supporting care leavers is not consistently understood across agencies and a misunderstanding could lead to unsafe assumptions.

10.3.1 Some health professionals do not understand the role and responsibilities of a PA (Personal Advisor) or the nature of support for care leavers. They were aware that the PA was supporting Mother but were less clear about the nature and extent of that support. The PA saw Mother 5 weeks after the birth and occasionally before the birth. Some health professionals said they assumed that the PA had met Father pre and post birth but they did not check this out. The review concluded that professionals were focussed on Mother and baby but no one had a good enough understanding of Father or his ability to parent or if he had any service needs in his own right as a new parent.

10.3.2 Mother was keen that although the relationship had broken down she wanted Father to "step up" as the father and take some childcare responsibility and provide her with help for the care of their baby, which he did. Health

professionals observed on one occasion that he was rather distanced but on another occasion that he was interacting well with Mother and their baby.

10.3.3 The Care Leaving Service works with many young parents. Mother's PA felt confident that she was able to support Mother because of their positive relationship and had no concerns that warranted greater involvement. The PA believed that other professionals knew she was involved and would contact her if they had any worries relating to Mother or the baby. The absence of any such reports indicated the view of health professionals that they had no concerns about Mother's care of her baby and that all was well both before and after Child F's birth.

10.3.4 Questions for the Board – Finding One

- **What measures will the Board put in place to improve multi-agency understanding of the support for care leavers?**
- **How will the Board clarify the parameters of role of the PA in the care leaving system to all other agencies to prevent confusion and any misplaced assumptions going forward?**

10.4 Finding Two: The fragmented health record systems do not ensure timely and reliable information sharing, which is at the core of an effective safeguarding system.

10.4.1 This manifested in this case in several ways:-

- There can be limited communication between GPs and wider multi-agency professionals. This is seen as a generic issue and not specific to this particular case or practice. This can distance GPs and primary care from known risks and safeguarding concerns about a family. Mother moved home during pregnancy and was able to opt out of antenatal care with no knowledge of her GP.
- GPs and Health Visitors do not work as closely as they did when Health Visitors were based in GP practices. GPs used to meet with Health Visitors to go through all cases in preparation but no longer since NHS structural changes.
- Whilst Midwives pass information to a central information system to be available to colleagues, the fragmented nature of antenatal records works against continuity of assessment of needs and care. One midwife stated there are "too many systems that do not talk to each other" which impairs information sharing amongst health colleagues. Another Midwife said she was "horrified" to find during the review that the e-booking system held further information she was not aware of.
- During the admissions of 9 and 11 June, the doctors very much dealt with what was before them but they lacked context and this was not easy to capture given the practical difficulties in accessing information about Child F, which was held in numerous places across the NHS. One might say, like the professionals stated, that this is ever thus but SCR

after SCR states the risks exposed by the fragmented nature of information held on an individual across the NHS and, while the reviews look to multi agency information, the NHS in itself has a great challenge in this regard.

10.4.2 Questions for the Board - Finding Two

- **How will the Board work to support, primarily health organisations to improve their information systems to allow the free and accurate passage of information across the NHS and cross county so that professionals can access the fullest information when they first become involved with an individual?**
- **How will the Board support professionals in a care standard that requires midwives to actively seek information and explore the social circumstances of a family and risk prior to discharge after birth.**
- **How can medical records be flagged to alert professionals that a mother and/or father is working with other key agencies or professionals such as a PA.**

10.5 Finding Three: Fathers continue to be of secondary or sometimes given little or no consideration by professionals in the safeguarding system

10.5.1 Whilst some professionals did make observations of Father, hearing from Mother about his reaction to becoming a father and his contribution to the care of their baby; as well as noting his distance on one occasion and appropriate interaction on another; and the fact that he sought help when he thought his baby unwell, it appears no one actively approached him pre or post birth to ascertain his views on becoming a father; his expectations on what that may involve or what he considered he could offer in terms of parenting. The review identified that Father had been excluded by professionals and his views, support and coping mechanisms were unknown and no one knew if he presented any potential risk to the family or if he would cope as a father.

10.5.2 Mother was expressing that she wanted to end the relationship but that she expected Father to undertake his responsibilities and provide care for his baby, including looking after him while she was out with friends. While all agencies said for this review that they are aware of the dangers of focussing just on the mother, that awareness did not translate into an appropriate level of curiosity about Father, and a good enough understanding of his strengths, needs or risks.

10.5.3 Learning from national serious case reviews show that professionals will focus upon mothers particularly where the father may not live with the family all the time. No assessment was made with regards to the impact upon Father as a young father of an unplanned baby with a mother with whom he had no enduring relationship. Nor do we know of the maturity of Father to meet the challenges of becoming a parent for the first time or being left to care for his baby alone. Professionals were not able to say whether he was well equipped to

do so in terms of maturity or ability. This was even more important given the health problems their baby had experienced in the first few weeks of life and the parents' anxiety about his wellbeing. As previously indicated, it has not been possible to ascertain Father's perspective as to what support needs he may have needed pre and post birth of his baby.

10.5.4 Questions for the Board - Finding Three

- **How can professionals from all agencies be supported to ensure an appropriate focus on fathers, as much as mothers?**
- **How can professionals be supported to work more actively with young fathers in particular?**
- **How can the Board be reassured that fathers are not being excluded in any considerations around parenting and safeguarding?**

Appendix 1 - Acronyms and Glossary

Working Together to Safeguard Children, 2013. The statutory guidance for inter-agency working to safeguard and promote the welfare of children. This guidance was updated in 2015

111 – Out of Hours medical service when GP surgeries are closed

CAF – Common Assessment Framework. Inter-agency assessment framework to identify the needs of children and young people with additional needs.

Care Leaver – a young person who has previously been in the care of the Local Authority

FNP – Family Nurse Partnership. A programme of support for vulnerable first time mothers.

GP – General Practitioner

HV – Health Visitor

LSCB – Local Safeguarding Children Board

MARU - The Multi-Agency Referral Unit provides a response to referrals of concern about children and young people

NHS – National Health Service

NICE – National Institute for Health and Care Excellence

PA – Personal Assistant (within Social Care Leaving Care Service)

Red Book – a small book that remains with the parent and where information about a child's growth and development is recorded.

SCARF – Safeguarding Children Assessment and Referral Form internal safeguarding notification used within Health to indicate concern about a family's vulnerability but not concern at a level that meets threshold for a referral to Social Care.

Centiles- a graph with lines showing average measurements of height, weight, and head circumference compared with age and sex, against which a child's physical development can be assessed. The lines of growth on the graph are called *centiles* (or *percentiles*), and the number of a centile predicts the percentage of children who are below that measurement at a given age; for example, the 10th centile means that 10% of the age- and sex-matched population will be smaller and 90% will be bigger. Children whose growth lies outside the 97th or 3rd centiles may need to be investigated.