SERIOUS CASE REVIEW
Baby E and Baby F

Independent Reviewer
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June 2019

INTRODUCTION

Events leading to this Serious Case Review

1. Towards the end of 2018, a six week old baby was taken to hospital, described as "pale and floppy." Examination of the baby showed that she had suffered serious head trauma considered to have been caused by violent shaking. The brain injuries are likely to have caused permanent damage and lifelong disability. This baby is known as Baby E and is twin to Baby F.

2. During further examination both children were found to have historical healing fractures.

3. A Child Protection investigation began and Care Proceedings were initiated to ensure the babies (and an older sibling) were protected; an investigation is taking place to find out how the injuries were caused and who was responsible. There will be a Finding of Fact[1] hearing in the Family Court and a decision about criminal charges will be made in due course.

4. The local Safeguarding Board carried out a Rapid Review[2] which concluded the case met the criteria for a Serious Case Review. The recommendation was endorsed by the National Panel[3] and the process began.

Method

5. The local Safeguarding Children Board had not yet fully implemented the new arrangements set out in Working Together 2018 therefore the method and terminology is that described in Working Together 2015. The Serious Case Review sub-group oversaw the process and an Independent Reviewer commissioned.

6. The Review covered a period of 11 months, comprising the mother's pregnancy and the six weeks leading up to the discovery of the babies' injuries. Written reports were requested in the form of chronologies, analysis of events and conversations were held with the

[1] A Finding of Fact hearing considers evidence in the Family Court in order to determine what happened and who might have been responsible. The Family Court is not a criminal court and cannot prosecute parents, the findings are based on the balance of probability and reported by a Family Court Judge. The findings can be used by other agencies to inform planning for children.
[2] Rapid Review – Safeguarding Boards are required to undertake a Rapid Review into all serious child safeguarding cases within fifteen working days of becoming aware of the incident.
[3] The National Safeguarding Practice Review Panel decides if a Serious Case Review (WT 2015)/ Local Child Safeguarding Practice Review (WT2018) is required and informs the local LSCB/Partnership of their decision.

agency authors and practitioners. Learning was identified and considered in the light of current research and relevant evidence from other Serious Case Reviews.

7. Chronologies were requested from:

- Midwifery
- Health Visiting
- GP
- Children's Social Care (Care Proceedings)
- Nursery (older sibling)
- Children's Hospital
- Police

Family Background

8. Both parents are White British and were in employment, they lived in an owner/occupied house in an area of mixed economic prosperity.

9. The couple have an older child who was 2½ years old when the twins were born. The sibling had started nursery just before the twins' birth and the nursery staff had no concerns about his well-being or development and had not observed anything unusual in the parent/child relationship.

10. The family were known to health professionals, the GP, Midwifery and Health Visiting, they had not come to the attention of Children's Social Care or the police.

Family Participation in the Review/Parallel Proceedings

11. At the time of writing Care Proceedings and the criminal investigation were underway. Whilst acknowledging the value of family participation in Reviews, in consultation with the Investigating Officer, it was decided not to involve the babies' family as this could potentially compromise evidence. This decision will be revisited at the end of the criminal process and Finding of Fact.

Anonymisation

12. For the purposes of anonymisation the family members are referred to as follows:

- Baby E – the twin subject to the brain injury
- Baby F – the other subject twin
- Sibling – aged 2½ when twins born
- Ms BM – Babies' mother
- Mr BF – Babies' father

SUMMARY OF EVENTS

Week Number	Event
1	Ms BM pregnant. Second pregnancy, sibling aged 2 years.
4	Booking with community midwife
6	Twin pregnancy confirmed. Ms BM has 11 contacts during pregnancy with Health and Midwifery services, this is higher than average due to the twin pregnancy and some related maternal health issues.
32	Sibling 2 year developmental review with a Health Visitor who used the opportunity to carry out an pre-birth "assessment." Ms BM informed the Health Visitor she was expecting twins. There are no concerns about the family suggesting they need additional support.
38	Baby E and Baby F born by planned Caesarean section. The babies' weight was within normal limits. The delivery was complicated by post-partum haemorrhage.[4]
39	Ms BM and the babies return home.
39	Midwifery visit daily for the first week, 8 visits altogether.
39	During the first midwife visit Mr BF is described as being "very angry". The source of his anger, directed at the midwife, was recorded as being about his wife's experience of the birth process.
40	Health Visiting make a new birth visit[5] but the visit is disrupted because the parents are concerned Baby F is unwell. A 111 call results in an paramedic visit and the baby is taken to hospital.
40	Baby F is examined and the parents reassured, the baby is treated for oral thrush and returns home.
41	The Health Visitor makes a second visit and discusses with Ms BM the subjects normally covered in the "new birth" visit.
44	Baby E, aged 46 days, is found to be pale and floppy and is admitted to hospital where, after examination, she is found to have suffered a serious head trauma considered to have been caused by a shaking injury. She also has two fractures of varying ages. Baby F has a leg fracture.
44 and ongoing	A Child Protection investigation is initiated followed by Care Proceedings and the children are placed with foster carers. A criminal investigation begins to try and establish who is responsible for the babies' injuries.

[4] Postpartum bleeding or postpartum haemorrhage (PPH) is often defined as the significant loss of blood within the first 24 hours following childbirth. The most common cause is poor contraction of the uterus following childbirth.
[5] New birth visit - The first visit made by the Health Visitor at home after the baby is born, where health visitors will check on the health and wellbeing of the parents and baby, support with feeding and other issues and give important advice on keeping safe and to promote sensitive parenting.

FINDINGS

THE PREGNANCY

13. According to NHS England statistics, multiple pregnancies (including twins) occur in 1 in 65 births.[6] When a twin pregnancy is diagnosed some additional health screening is provided. In this case the babies developed normally but Ms BM had some additional health needs including gestational diabetes[7] and low iron levels.

Midwifery

14. As a result Ms BM has a higher than average number of contacts with health services, 11 contacts in total.[8] There was good continuity, with Ms BM seeing the same midwife on a number of occasions enabling a relationship to be established. Mr BF attended the majority of appointments with his wife.

15. During the ante-natal period it is expected practice that, in addition to medical care, midwives will carry out an assessment of the family to determine if they have any additional needs which may require referral for support services. The current policy reminds practitioners that the risk of domestic abuse is higher during the period of pregnancy and immediately after the birth (puerperium) and that midwives need to be alert to signs and symptoms. In this case the records indicate an assessment took place and nothing of concern was identified.

GP Involvement

16. Ms BM had expressed some anxiety to her GP about the pregnancy as she had experienced a traumatic birth with her first child. In addition to the contacts with maternity services, during her pregnancy Ms BM had over 30 contacts with her GP surgery for ailments, mostly associated with the pregnancy; this included the gestational diabetes which required monitoring and management in order to reduce the risk of harm to the unborn twins.

17. The professionals who had contact with Ms BM and Mr BF during the pregnancy were up to date with their safeguarding training and aware that multiple visits to a GP with minor ailments may be an indication of emotional distress or underlying difficulties, for example

[6] In 2013 around 11000 sets of twins and about 200 sets of triplets, or more, were born in the UK. That means that about 1 in every 65 births in the UK today are twin, triplets or more. This is a big increase from 1984 when 1 in every 100 births was a multiple birth.
https://www.nhs.uk/conditions/pregnancy-and-baby/what-causes-twins/

[7] Gestational Diabetes is high blood sugar that develops during pregnancy if the body cannot produce enough insulin to meet the extra needs of pregnancy. It can cause problems for the unborn baby during and after the birth, the risk of ongoing problems is reduced if it is well managed.

[8] For a single, uncomplicated pregnancy, 4 or 5 contacts with midwifery would be average.

stress or depression. Staff at the practice were trained in the IRIS programme[9] and were observant of indications of domestic abuse, there were no indications of risk in this case.

18. Given Ms BM's health issues associated with the pregnancy, there was no indication that there was anything unusual about the frequency of contact.

19. During the ante-natal period there was no indication of any safeguarding issues or that the family would have benefitted from referral for support services.

THE BIRTH

20. The twins were born by a planned Caesarean Section at full-term, their weights were Baby E, 2868g (6lb 5oz) Baby F 3282g (7lbs 3oz)

21. The birth did not go smoothly, Ms BM suffered a post-partum haemorrhage, as she had when her first child was born. Having returned to the ward after the birth, she suffered a second haemorrhage and had to have further surgery with a general anaesthetic. This left Ms BM bruised and sore, extending her recovery time.

THE TWINS AT HOME

22. 48 hours after the birth Ms BM and the babies were discharged home. The doctors and midwives had no concerns about the health or well-being of the twins or Ms BM. In line with policy and usual practice, a community midwife visited the family daily for a week and then made two further visits before handing the case over to a Health Visitor.

23. There were two issues of note during this period.

24. On the first midwife visit, the day after discharge, when the twins were four days old Mr BF was described by the midwife as being "very angry." In her record, the midwife ascribed his behaviour to his feelings about his wife's experience during child birth. (This midwife has since retired and was not available for a first-hand account of the incident.)

25. Other records show that Mr BF was present during the visits and was frequently observed holding both babies, appearing to have taken on a substantial role in child care. Ms BM

[9] IRIS is a general practice-based domestic violence and abuse (DVA) training support and referral programme including training and education, clinical enquiry, care pathways and an enhanced referral pathway to specialist domestic violence services.

was observed as being “weak, tired and in pain” and with a “flat” demeanour. On another visit, the 2½ year old sibling was described as “manic,” his behaviour being very disruptive, but managed well by Ms BM.

26. The second finding of note was that Mr BF and Ms BM were reported as being anxious about Baby F having some feeding difficulties and slow weight gain. This is significant because the couple had experienced similar circumstances with their first child who was later diagnosed with a congenital medical condition requiring life-long medication.

27. By the time the midwife visits came to an end, Ms BM was described as being “completely different” her mood had lifted and she was answering the door and moving better, “as if in less pain” from her surgery.

28. The midwife did not discuss Mr BF’s angry feelings, Ms BM’s anxiety about the pregnancy and birth and the couple’s continuing anxiety about Baby F’s feeding with the Health Visitor.

Health Visiting

29. Health Visiting had met the family on three occasions during the period of this Review and had two telephone calls. The first meeting was the “pre-birth assessment.”

The Pre-Birth Assessment

30. This took place when an opportunity arose when at the siblings two-year developmental assessment; the appointment took place at the local clinic and Ms BM and Mr BF were both present. In line with the information sharing policy, Midwifery had informed Health Visiting about the pregnancy, it was at this meeting that Ms BM, now seven months pregnant, told the Health Visitor she was expecting twins.

31. The Health Visitor reports that after the siblings review, she spoke to Ms BM and Mr BF about “responsive parenting”[10] including, for example, the risks of co-sleeping and what parents can do if they “feel tense” (put the baby in a safe place and take time out to calm down) The Health Visitor did not complete the assessment required at the time which

[10] The Institute of Health Visiting, Healthy Start, Happy Start, (2017) promotes Responsive Parenting which is defined as family interactions in which parents are aware of their children's emotional and physical needs and respond appropriately and consistently. Sensitive parents are “in tune” with their children.

looks at the Child and Family Strengths, Needs and Risks or use the Promotional Guidance[11] approach required at the time.

32. It seems likely that at the time of the sibling's developmental review, in a clinic setting and with Ms BM experiencing ongoing serious maternal health issues, this was not the optimum environment or timing for conversations about "responsive parenting" to babies who were yet to be born.

33. In 2017, during a review of services, the benefits of ante-natal visits was described by managers as "undervalued" and they were not universally offered to prospective parents. Provision was described by practitioners as "opportunistic or targeted" although there were no specified criteria for the targeting.

34. Prior to the Review, the Health Visiting service had recognised the need for improvements in service delivery which are set out in detail in their Service Transformation Programme.[12.]

35. Since 2017 there have been changes, but by the summer of 2018, when Ms BM was pregnant, the anticipated improvements in practice had not yet embedded and practice was still inconsistent. A training programme to improve assessment skills was underway however the Health Visitor in this case was among the last tranche of staff to attend and, at the time of these events, had not yet received the training.

LEARNING POINT

- The pre-birth assessment is a valuable opportunity for Health Visitors to begin to establish a relationship with a family and provide a responsive service. The quality of the initial assessment will be improved, and more likely to be useful to new parents, if the contact is planned and purposeful and priority is given to discussing pregnancy, birth and parenting.

[11] Promotional Guidance promotes early infant development and early parenting using materials to facilitate personalised guided conversations with parents to explore key topics and priorities during pregnancy and early infancy.

[12] Service Transformation Programme - The plan sets out how health and care services will work in partnership to develop plans that will enable them to continue to meet the health needs of the local population at a time of increasing demand and constrained resources. To read the plan and the summary document and watch a video providing an overview, see the South Gloucestershire Clinical Commissioning Group website.

Information for Parents

36. The practice at the time, and currently, is that parents are not given any information in writing, in the form of leaflets, booklets etc. about the myriad of subjects relevant to new parents. This is because feedback from parents to Health Visiting indicated that they felt an "information overload" and did not read most of the written information. Current practice is that all useful information is contained in the "Red Book" which is given to parents for each child, to record their medical history and development. The Book also contains information about, for example, feeding, sleeping and coping with crying.

37. The Red Books have recently been updated to include information about the risks of shaking babies, but this was not present when the twins were born.

Discharge Summaries

38. When the Community Midwife's role comes to an end the policy is that a discharge summary is completed and passed on to the Health Visitors. This is a paper exercise and the completed document is passed to Health Visiting for filing.

39. This process of information exchange was not working well. Practitioners acknowledged that discharge summaries rarely appeared before the case was handed over and the Health Visitors made their first visit and, when they were produced, they might be filed without actually being seen.

40. In this case the Health Visiting team and Community Midwives are co-located, that is based in the same building; given the incidence of twin births, the complications of Ms BM's pregnancy and traumatic birth process and the relatively low number of "new birth" visits each Health Visitor undertakes, it is disappointing that the practitioners involved with this family did not communicate effectively at the point of handover.

41. From the limited information available, it seems that there was a total reliance on the discharge summaries, although the system was known to lack rigour. It was assumed that if any practitioner had "concerns" about a family, in this case the midwives, they would take steps to make sure Health Visiting were aware. This means that if there are no obvious safeguarding concerns, more nuanced information about, for example, the stresses of coping with twins, a new parent's anxiety about feeding or maternal health, will not be communicated.

LEARNING POINTS

- In this case it was the parents who informed the Health Visitor that the pregnancy was a twin birth. Pro-active communication between Midwifery and Health Visiting, particularly when there are additional vulnerabilities, is likely to lead to better continuity of care.

- Effective communication is a two way process which works well when information is both sought and shared by all professionals; effective information exchange will enable a more robust and timely assessment of the degree of stress or significance of anxiety experienced by parents and whether Early Help is indicated or there are any emerging safeguarding concerns.

Electronic Records

42. The practitioners participating in this Review were optimistic about the imminent introduction of electronic records and the benefits of being able to access information more easily.

43. Electronic records alone are not a substitute for effective communication between professionals and will not lead to improved service delivery without professional understanding and skill at managing the risk of information overload.

LEARNING POINT:

- Whilst electronic record sharing is a welcome development, it is essential that commissioners, managers and practitioners do not lose sight of the need for information sharing to be focussed and purposeful.

- It is essential to avoid information overload and ensure communication systems highlight key elements of risk. This will enable practitioners to consider the information alongside their professional knowledge and assessment skills.

BABY F IN HOSPITAL

44. The Health Visitor made a "new birth" visit when the twins were 11 days old. On arriving at the family home it soon became evident that Ms BM and Mr BF were anxious about Baby F who they thought was not gaining weight satisfactorily and who was more than usually sleepy.

45. In order to appease the parents, the Health Visitor who was not particularly concerned, suggesting calling the NHS helpline 111.[13] This resulted in a paramedic being sent and the baby being transported to hospital in an ambulance accompanied by Ms BM.

46. On arrival at hospital, Baby F was examined by a senior paediatrician who concluded she was generally well and prescribed medication for oral thrush before discharging her home. Expected practice is that the baby would have been undressed and weighed, although this is not recorded, nothing of concern was noted.

47. Given the guidance about the purpose of the NHS 111 number, it is surprising that a health professional considered this a better option than, for example, making an appointment with a GP.

Second Health Visitor Home Visit

48. A week later and in order to complete the new-birth visit, the Health Visitor called again and saw the twins with Ms BM. Mr BF was at home but remained upstairs "hoovering." On this visit the Health Visitor saw both babies and covered the subjects of responsive parenting, the risks of depression and domestic abuse and availability of family support. There were no indications of anything suggesting the twins were at risk of harm.

THE INJURIES

49. Four weeks after the second visit from the Health Visitor Baby E, aged 6½ weeks, was taken to hospital by ambulance after being described by Mr BF as "pale and floppy" when she woke for a feed. The baby was admitted for observation and suffered a seizure. Medical investigations showed she had suffered a subdural haemorrhage thought by the medical

[13] 111 is designed to facilitate easy access to NHS health care services in England if health care advice is needed and urgent help is required but the situation is not life-threatening. The Guidance indicates that the service is for those who "don't know what to do" or who don't have access to a GP or health advice.

staff to have been caused by shaking. The baby is likely to have suffered permanent brain damage which will leave her with a life-long disability.

50. After further examination and x-rays, both babies were found to have fractures of varying ages. At the time of writing there had been no explanation for the injuries or identification of who was responsible.

Abusive Head Trauma (AHT)

51. Abusive Head Trauma is defined as:

    "*an inflicted injury to the head and its contents" and "associated with a spectrum of serious and often permanent neurological consequences"*

52. Alison Kemp in her paper "Abusive Head Trauma: Recognition and Essential Investigation" states that:

    "*Abusive head trauma (AHT) affects one in 4000–5000 infants every year and is one of the most serious forms of physical child abuse that has a high associated mortality and morbidity."* [14]

53. It is seen as a leading cause of death in children under 2 years old.[15]

54. The research proposes that AHT is largely preventable and suggests that the most common incident leading to abusive head injury is infant crying; [16] and that the person most likely to shake an infant "is the father or male surrogate"[17]

55. The research about AHT and prevention indicates that in order to be effective a strategy for prevention should promote awareness of the dangers of shaking in response to crying and ensure fathers and male carers are included in education.

56. During pregnancy and after the birth of the twins the family were given some information about responsive parenting. The practitioners involved in this review indicated that during pregnancy the emphasis of health promotion is on feeding, after the birth the information for parents is found in the Red Book which at this time had no information about the risks of shaking and associated head trauma.

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[14] Abusive head trauma: recognition and the essential investigation Alison M Kemp, Abusive head trauma: recognition and the essential investigation Alison M Kemp. BMJ, September 2012.

[15] Abusive head trauma: Evolution of a diagnosis
Issue: BCMJ, Vol. 57, No. 8, October 2015, page(s) 331-335
Margaret Colbourne, MD, FRCPC

[16] Dr Suzanne Smith, Mechanisms, Triggers and the Case for Prevention, January 2017

[17] Parent Education by Maternity Nurses and Prevention of Abusive Head Trauma
Robin L. Altman, Jennifer Canter, Patricia A. Patrick, Nancy Daley, Neelofar K. Butt, Donald A. Brand

LEARNING POINT:

- The research into AHT indicates that it can be prevented by providing evidence-based education programmes aimed at supporting parents in coping with crying.

CONCLUSION

57. When the work done with a family is scrutinised in detail, it is almost inevitable that a Review will conclude that some of the practice could have been better. In this case maternity services and Health Visiting have identified some weaknesses in their systems which require improvement.

58. Midwifery have identified a need for all recording on patient records to be properly signed and also general frustrations among staff about the adequacy of notes and templates. Whilst these issues did not affect the outcome of this case, they require further work.

59. For Health Visiting the service provider changed in 2016. In 2017 the new arrangement was confirmed and an assessment of staff development needs was undertaken as a precursor to the Transformation Plan. The service recognised that it was not performing well and is currently attempting to improve performance by setting out clear policy expectations, skill development and moving from a medical model of service delivery to a more holistic approach.

60. In 2018 when Health Visiting was working with this family, the "transformation" was underway but the family's Health Visitor had not yet completed the associated training. Pre-birth assessments are reported as being more consistent and of better quality.

61. The effectiveness of communication between Midwifery and Health Visiting remains a serious concern which impacts on continuity of care and effective assessment. The chronologies requested as part of this Review indicate that there is little effective communication at a strategic level, an Agency Reviewer reflected on feeling "unwelcome" at strategy meetings and questioned their effectiveness indicating that there are systemic issues to be addressed.

62. Communication between practitioners working with families was described by participants in this review as "inconsistent "or "variable."

63. As a consequence there is no effective mechanism for improving continuity of care within agencies (health providers) or sharing information about individual families unless the threshold for Early Help or Child Protection is met. Information about, for example, the potential impact of parental anxiety on child development, the significance of the experience of pregnancy, are less likely to be considered as part of an assessment of need.

64. Apart from increased medical input, there appeared to be no consideration among practitioners of the added stress of parenting twins, particularly in families with other young children. During the past five years SCRs about cases involving twins indicate common themes.[18] Research is limited but some studies suggest there is an enhanced risk of harm when there is a multiple birth.[19] Common themes among the published SCRs[20] are the high incidence of prematurity in multiple births leading to babies spending time in special care, with a potential impact on attachment, the babies extra health needs, additional parent vulnerabilities and lack of discharge planning.

65. Abusive head trauma has devastating consequences for babies and children, it may not be predictable but the research shows that health promotion strategies highlighting the risks of shaking can help prevent injury. Ongoing learning from this and other practice reviews point out that It is essential that men and fathers are not just present during appointments and meetings, but are actively engaged in learning about the risks.

[18] See NSPCC Repository.
[19] For example see Lang CA et al, Maltreatment in Multiple Birth Children. Child Abuse and Neglect, 2013.
[20] See for example "BY" Blackpool Safeguarding Children Board 2018, Baby H Oldham Safeguarding Children Board 2018, Baby A and Baby B, Somerset Safeguarding Children Board, 2013.

CONSIDERATIONS FOR THE SAFEGUARDING CHILDREN BOARD

66. The learning from this case comes from the detailed analysis of practice and focuses on:

- Abusive head trauma and how it can be prevented;
- The impact on parenting of multiple births, parental anxiety and additional vulnerabilities which arise from multiple births;
- Working arrangements between Midwifery and Health Visiting, both at a strategic and operational level.

Recommendations:

67. The LSCB should;

- Consider a public health campaign to promote awareness of AHT informed by current research into how AHT can be prevented and what existing resources and strategies are available including those specifically aimed at fathers and male care givers.
- Ensure that commissioners and managers are evaluating the impact of the Health Visiting Transformation Programme and outcomes for children particularly with regard to assessment.
- Consider how to improve professional relationships to enable agencies, particularly Midwifery, Health Visiting and GPs, "to offer help and support in an integrated way." [21]
- Consider the significance of multiple births and whether there should be an enhanced information sharing protocol or service delivery;
- Seek assurances that the introduction of electronic records has a positive impact on safeguarding practice.

[21] From South Gloucestershire Draft Early Help Strategy for Children Young People and Families, 2019 – 2014.

SUMMARY OF LEARNING

A. The pre-birth assessment is a valuable opportunity for Health Visitors to begin to establish a relationship with a family and provide a responsive service. The quality of the initial assessment will be improved, and more likely to be useful to new parents, if the contact is planned and purposeful and priority is given to discussing the pregnancy, birth and parenting.

B. In this case it was the parents who informed the Health Visitor that the pregnancy was a twin birth. Pro-active communication between Midwifery and Health Visiting, particularly when there are additional vulnerabilities, is likely to lead to better continuity of care.

C. Effective communication is a two way process which works well when information is both sought and shared by all professionals; effective information exchange will enable a more robust and timely assessment, including the degree of stress or significance of anxiety experienced by parents and whether Early Help is indicated or there are any emerging safeguarding concerns.

D. Whilst electronic record sharing is a welcome development, it is essential that commissioners, managers and practitioners do not lose sight of the need for information sharing to be focussed and purposeful.

E. It is essential to avoid information overload and ensure communication systems highlight key elements of risk. This will enable practitioners to consider the information alongside their professional knowledge and assessment skills.

F. The research into AHT indicates that it can be prevented by providing evidence-based education programmes aimed at supporting parents in coping with crying.

APPENDICES

Agencies Participating in the Review

Avon and Somerset Constabulary
North Bristol NHS Trust Maternity Services
Sirona (Health Visiting)
University Hospitals Bristol NHS Foundation Trust
South Gloucestershire Children's Integrated Services
Nursery
Bristol, North Somerset and South Gloucestershire (BNSSG) CCG GP Practice

Membership of the SCR Sub-Group

Head of Safeguarding, South Gloucestershire Council - Chair
Head of integrated Children's Services, South Gloucestershire Council
Legal Services, South Gloucestershire Council
Designated Doctor, BNSSG CCG
Area Manager, Lighthouse Safeguarding Unit, Avon & Somerset Police
Head of Education Learning & Skills, South Gloucestershire Council
Specialist Health Improvement Practitioner, Public Health
Service Manager, Next Link Domestic Abuse Services
SGSCB Business Manager