



Serious Case Review

CHILD C

SOUTH GLOUCESTERSHIRE LOCAL SAFEGUARDING

CHILDREN BOARD

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Author
Andrew Haley

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1. Summary

- 1.1 This Serious Case Review was commissioned following the death at the age of 17 weeks of Child C. At the time of her death she was living in a household with her brother, her mother and her mother's boyfriend.
- 1.2 The father of Child C was a young man similar in age to her mother. Although the relationship was longstanding it was not continual. They had never lived together as a family and at the time of her death her parents were not in a relationship.
- 1.3 Child C had been receiving help during her short life from several agencies, including Children's Social Care.
- 1.4 During **August 2012** her mother met a new partner, mentioned in 1.1 above, and he moved in to join the family.
- 1.5 On the **12th September 2012** a small bruise on the side of Child C's head was noted and an accidental explanation was offered by the children's mother.
- 1.6 Just under a month later, on the **5th October 2012**, Child C was seen at the Children's Hospital with injuries to her eyes. Her mother explained she believed the injuries were caused by Child C's brother spraying her with hairspray.
- 1.7 On **31st October 2012** Child C was again taken for medical attention suffering a swelling on her forehead, said to have been the result of being dropped by Child C's mother's boyfriend.
- 1.8 On the **6th November 2012** Child C's mother left a message for her health visitor concerned that Child C's brother was hitting Child C and bruising her face.
- 1.9 On **14th November 2012** Child C was conveyed to hospital by ambulance from her home. Child C was not breathing and had been pronounced dead at home.
- 1.10 After Child C's death some other observations were made during the initial post death clinical examination at the hospital and during the forensic post mortem. Blisters to her neck and ears were observed and have since been identified as possibly caused by the skin infection impetigo. Bruising was found on Child C's scalp, thought to be some days old.
- 1.11 Child C's death is recorded as due to unascertained causes.

2. The Requirement to Undertake a Serious Case Review¹

¹ Working Together 2013

Serious Case Reviews (SCR) are local inquiries into the death or serious injury of a child where abuse or neglect is known or suspected to be a factor. They are carried out by Local Safeguarding Children Board so that lessons can be learnt. The Local Safeguarding Children Board is responsible for ensuring that a review is undertaken.

- 2.1 Working Together 2013 is HM Government Guidance which sets out how SCRs should be carried out.
- 2.2 Local Safeguarding Children Boards (LSCBs) are required to maintain a local learning and improvement framework which is shared across local organisations who work with children and families.
- 2.3 LSCBs may use any learning model which is consistent with the principles in the guidance, including the systems methodology recommended by Professor Munro.
- 2.4 The case of Child C was considered by the LSCB Serious Case Review sub group in December 2012 but the final decision as to whether a SCR be undertaken was delayed pending the outcome of the post mortem. In June 2013, following receipt of the post mortem report, the SCR sub group recommended to the Chair of South Gloucestershire Safeguarding Children Board that the threshold for a Serious Case Review had been met. The Chair of the Board accepted this recommendation and decided that a Serious Case Review should be undertaken.
- 2.5 An independent Overview Author and Chair of the Serious Case Review Panel was commissioned. The Author is independent from any of the agencies who provided services to Child C and her family. A short biographical note on the Independent Overview Author is attached at Appendix 5.

3. Summary of Individual Organisation Reviews and Terms of Reference

The time period identified for this Serious Case Review is from 1st September 2008, due to the relevance of the family context in understanding the background, until the death of Child C on 14th November 2012

- 3.1 Representatives from agencies who had provided services to Child C and her wider family produced Individual Organisation Reviews. These were undertaken by suitably qualified staff that had no direct involvement or management of the case under consideration.
- 3.2 The agency authors were tasked to look openly and critically at the individual and organisational practice to get a narrative of how the case was viewed as it unfolded; identify key practice episodes and turning points; analyse the contributory factors and interpret the broader significance from the information gathered to see whether the case

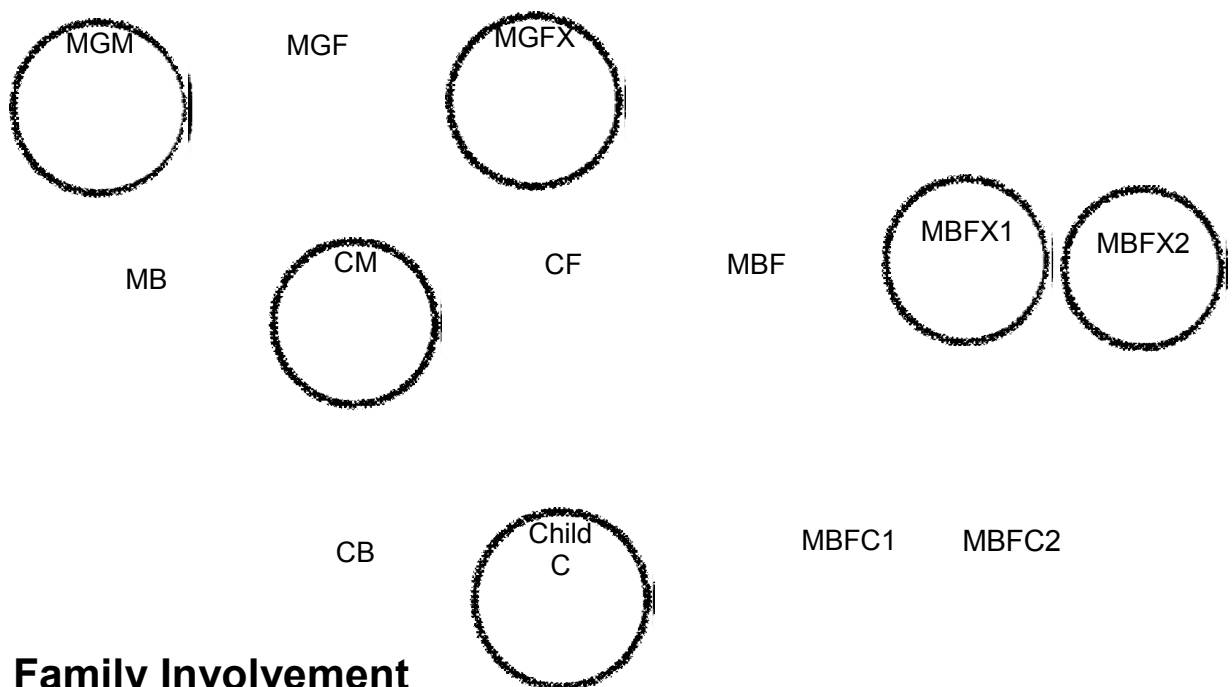
indicates that changes could and should be made and, if so, to identify how those changes will be brought about.

- 3.3 The Individual Organisation Review provides a chronology and analysis of the agency involvement and brings together and draws overall conclusions from the involvement of the agency with Child C and her family. The Individual Organisation Review authors also had direct discussions with staff from within their agencies whom it was thought could assist with the overall understanding. The combined chronology and the Individual Organisation Reviews from each agency were considered by the Independent Author to construct the Overview Serious Case Review Report.

4. Family Composition

Family Composition and Background

Relationship to Subject
Child C
Child C's Mother
Child C's Father
Child C's Brother
Child C's Mother's Boyfriend
Child C's Maternal Grandmother
Child C's Maternal Grandfather
Child C's Mother's Brother



5. Family Involvement

- 5.1 Child C's mother and maternal grandmother were invited to contribute to the Serious Case Review process and met with the Serious Case Review Overview Author. They each provided information they thought would be helpful in these considerations. They were provided with a record of that meeting and corrected any misunderstandings or errors of fact.

- 5.2 Child C's father was invited to participate but he declined. The Panel received communication on his behalf saying that he did not choose to participate.

6. The Family Story

Child C and her Family

- 6.1 In order to fully understand the family functioning at the time of the death of Child C, it is necessary for us to understand the history of her mother. This report considers this context, as well as understanding the day to day life of Child C. This report looks at:
- what was happening for the front line professionals involved with Child C;
 - what influenced the decisions they made;
 - whether, if different actions had been taken, this may have altered the outcome for Child C; and
 - what lessons need to be learned?
- 6.2 Munro (2008)² notes that 'the failure to look at history makes it easy to overlook patterns of behaviour yet these are often the most reliable warning'.
- 6.3 Child C's mother is one of two full siblings, the daughter of Child C's maternal grandmother and grandfather. Child C's maternal grandmother met Child C's maternal grandfather when she was 21 years and he 45 years. Child C's maternal grandmother reports this relationship to be oppressive following on from an unhappy childhood, with little attention and support from her own parents.
- 6.4 Child C's mother did not attend school until her GCSE year, being electively home educated. Child C's mother's brother was also educated at home but he was placed in school during his junior years as his mother found his behaviour too difficult to manage. Significantly, both Child C's maternal grandmother and Child C's mother report now that Child C's maternal grandfather was physically and emotionally abusive. They said in discussion, when interviewed as part of the Serious Case Review process, that he was oppressive and overbearing, a habitual cannabis user and drank heavily. The domestic abuse was not discussed with outside agencies during this period. The Education Welfare Officer who monitored the Elective Home Education arrangements was not aware of the violence within the family.
- 6.5 Prior to 2005, her health records show infrequent GP appointments. In 2005 she was seen on 10 occasions with minor skin problems. In 2006 she was seen on 9 occasions with recurrent minor medical problems. In 2007 she was seen 15 times presenting with similar problems. On occasions the consultation was recorded as stress related and to be

² E Munro Effective Child Protection Practice 2nd Edition 2008

rooted in family and emotional problems. On one occasion Child C's mother presented with a wrist injury as a result of a fight with her brother. In 2008, before her pregnancy with Child C's brother, she was seen on 13 occasions. A young person aged between 5 and 25 would have an average consultation rate with GP services of 2-3 consultations per year.³

- 6.6 During 2007 and 2008 Child C's mother became an increasing visitor to her GP's surgery.

2008

- 6.7 In May 2008, Child C's maternal grandmother left the family home and took her children to live elsewhere. Children's Social Care undertook an Initial Assessment⁴. No services were provided as an outcome of this assessment as Child C's maternal grandmother was acting protectively and there was no contact with Child C's maternal grandfather.
- 6.8 In August 2008 Child C's mother's family were referred to South Gloucestershire Children's Social Care. Child C's maternal grandfather had accepted a police Caution following admitting physically assaulting Child C's mother who was 14 at the time.
- 6.9 Towards the end of 2008, Survive⁵ made a referral to Children's Social Care. They were working with Child C's maternal grandmother. The Survive worker enclosed the CAADA/DASH⁶ risk assessment which indicated a very high risk. The risk was perceived to be from Child C's maternal grandfather. The assessment included information that Child C's mother, then 15 years old, was 8 weeks pregnant and that her needs required Children's Social Care involvement and that, in their view, there was potential for significant harm. Children's Social Care considered the information and concluded that as a Lead Professional and a CAF⁷ was in place, this level of intervention was appropriate and there was no requirement for Children's Social Care involvement.
- 6.10 Support was provided by the Survive service. It seems that both Child C's mother and Child C's maternal grandmother were and remained fearful of Child C's maternal grandfather. This is not unusual in

³Trends in Consultation Rates in General Practice 1995 to 2006: Analysis of the QRESEARCH database

⁴ A decision to gather more information constitutes an initial assessment. An initial assessment is defined as a brief assessment of each child referred to social services with a request for services to be provided. This should be undertaken within a maximum of 7 working days but could be very brief depending on the child's circumstances. It should address the dimensions of the Assessment Framework, determining whether the child is in need, the nature of any services required, from where and within what timescales

Framework for the Assessment of Children in Need and their Families HMSO 2000

⁵ Survive is a voluntary organisation who work with the victims of domestic abuse

⁶ CAADA - Coordinated Action Against Domestic Abuse

⁷ CAF is Common Assessment Framework. An assessment following the framework undertaken by any professional working with a family, below the intervention level where Children's Social Care become involved

circumstances where abusive individuals have exercised such levels of intimidation and control. 'All forms of domestic violence come from the abuser's desire for power and control over an intimate partner or other family members'⁸.

2009

- 6.11 Child C's mother's first pregnancy was difficult. She suffered from a complication of pregnancy that caused nausea, vomiting and dehydration throughout, on occasion requiring hospitalisation. The Primary Care Individual Organisation Review author suggested that this level of sickness may have had an underlying emotional cause.
- 6.12 The following month Child C's mother spoke to her Survive worker of her fears that her brother would harm her baby when born. This was a constant theme during this period because Child C's mother also expressed these concerns to her midwife. In contrast she also spoke of the positive impact of the Family Therapy they were receiving from Child and Adolescent Mental Health Service (CAMHS)⁹. The issues about Child C's mother's brother prompted Survive to make another referral to Children's Social Care and a subsequent discussion with the Duty Social Worker but this did not lead to any assessment by Children's Social Care as there was a CAF arrangement in place.
- 6.13 The other theme raised by Child C's mother in discussion with several professionals was the use of cannabis by Child C's father and his family. The midwife gave appropriate advice to the mother about ensuring that Child C's father did not smoke around the baby once it was born and not to leave Child C's father alone with the baby.
- 6.14 Child C's mother was still living in the family home at the time of the birth of Child C's brother.
- 6.15 On 9th July 2009 a notification of a domestic abuse incident was received by Children's Social Care from the police. This related to an argument between Child C's mother's brother and Child C's father.
- 6.16 Child C's Father later telephoned the police to express his concerns for the welfare of Child C's brother, their 2 week old baby. His main concern was that Child C's mother's brother had mental health issues and was violent towards Child C's mother and Child C's maternal grandmother. Child C's mother responded by taking her baby (Child C's brother) to the police station to demonstrate he was 'safe and well'. Officers followed their usual procedures, advising appropriate departments within the constabulary and other agencies.
- 6.17 On the 16th July 2009 Survive rang Children's Social Care to say that they were working with Child C's mother and that there were complex

⁸ The Survivors Handbook Women's Aid. Jackie Barron 2009

⁹ CAMHS Child & Adolescent Mental Health Service

issues which they felt required Children's Social Care involvement. A meeting was arranged to agree what to do next.

- 6.18 An Initial Assessment was undertaken by a social worker on 24th July 2009 in response to recent concerns. The outcome was 'no further action' from Children's Social Care. It is not clear from the records how this decision was reached.
- 6.19 On 28th July 2009 GP15 recorded that the child C's mother was under more stress because her father (Child C's maternal grandfather) had found out where the family were living. Child C's mother was afraid that Child C's maternal grandfather would come to the house and cause them harm. Child C's mother told the GP that there was a police flag on the property.¹⁰
- 6.20 Child C's brother was seen regularly by the Health Visitor and the Community Nursery Nurse. Child C's brother saw GPs 3 times before his eight-week check because of minor regurgitation of feeds, on each occasion there was a normal assessment.
- 6.21 On 6th August 2009 Child C's mother and Child C's maternal grandmother attended the police station and complained to police that Child C's aunt (father's sister) had been sending threatening text messages. Child C's mother was worried that the aunt may turn up at her house. Further investigation revealed there was no specific threat.
- 6.22 On 14th August 2009 the case was re-opened by Children's Social Care following information received from police regarding the above complaint.
- 6.23 On 11th September 2009 Social Worker 6 visited the family as the allocated Social Worker following the completion of an initial assessment. There is comprehensive recording of the visit which includes information that Child C's maternal grandmother has attended the Freedom Programme at Survive and that Child C's mother was receiving counselling through Survive and was well supported by a Connexions worker. Child C's mother was seeing a community nursery nurse from NHS Trust 1 and attending an educational facility for teenage mothers. Child C's mother's brother was reported to be attending school and had a mentor. Contact with Child C's father was discussed. Child C's mother felt that his family was putting pressure on her to take Child C's brother to their home but Child C's mother was resisting saying the family members smoke cannabis. Social Worker 6 suggested that contact take place at Child C's mother's family home.
- 6.24 During this period there was some inter-agency discussion illustrated by Social Worker 6 record of a visit to the family on 25th September 2009 and telephone calls to the Health Visitor, Connexions and Sure Start.

¹⁰ This is a 'Treat As Urgent' marker.

- 6.25 GP15 saw Child C's mother on 20th October 2009 because of recurrent abdominal pain. Increased stress levels were noted again in relation to the reported receipt of abusive and threatening texts from Child C's father's family who had accused her of abusing Child C's brother. There were also concerns about Child C's paternal grandmother who had allegedly rolled a 'joint' and then put her fingers in Child C's brother's mouth. GP15 sent a letter to Children's Social Care sharing these concerns.
- 6.26 There was a change of social worker on 14th December 2009.
- 6.27 On 22nd December 2009, when Child C's brother was 6 months old, he was reported by Child C's mother to GP15 to have fallen off a sofa. A full examination showed no evidence of injury or bruising. GP15 contacted the Health Visitor about this incident.

2010

- 6.28 Social Worker 7 visited the family on the 8th February and the 3rd March 2010. The case was closed following this last visit as it was recorded the family were 'doing very well'. Social Worker 7 discussed the possibility of a referral for an adolescent support worker at this time but expressed the view that he was concerned that Child C's mother would be 'flooded' with services and this might impede the development of her coping skills.
- 6.29 From January to April 2010 Child C's mother had minor medical problems which were attributed to stress. She was recorded by Health Visitor 1 to be managing Child C's brother well with support from her own mother (Child C's maternal grandmother).
- 6.30 From June to November 2010 Child C's mother saw several GPs on 12 occasions for minor problems.
- 6.31 The Health Visitor recorded Child C's brother as doing well. He had his immunisations at the appropriate stages and saw GPs with minor ailments on 3 occasions between July and October 2010.
- 6.32 On 29th November 2010 Child C's brother was registered at GP Practice 3, having moved house, and was seen by a GP because of an episode where his mother was reported to have woken in the night to hear the child making a choking noise and she found a small amount of blood staining on his sheet which she thought had come from the child's nose. Examination was normal.
- 6.33 In December 2010 Child C's mother saw the GP for minor medical issues.
- 6.34 Throughout 2010 there were incidents where police were contacted by either Child C's mother or maternal grandmother, either due to Child C's mother's brother's behaviour or fears in respect of Child C's father's family.

2011

- 6.35 In January 2011 Child C's mother again saw the GP for minor medical issues. On 28th January 2011 GP17 recorded that Child C's mother had a history of physical abuse from her own father (Child C's maternal grandfather), difficulty with family relationships and finding college very stressful. She was very distressed and talked of thoughts of self-harm but said she would not act upon them. The GP had a long and supportive discussion with Child C's Mother. Details were given of a counselling service and she was asked to make an appointment to see a GP again in a couple of weeks' time. There was no evidence of safeguarding issues being discussed with other professionals.
- 6.36 On the same day Child C's mother's brother was interviewed by police regarding damage he had caused to the homes of children from his school. There had been some unpleasantness, including threats posted on Facebook and he had responded by causing damage to the homes of those he thought were responsible. He told police he was depressed and felt suicidal. His mother (Child C's maternal grandmother) told officers that he had 'taken pills' two weeks earlier. She said she was very worried and did not know what to do.
- 6.37 Social Work Assistant 1 was allocated to the case. Social Work Assistant 1 was the constant Children's Social Care practitioner until the case was closed in September 2012. Other social workers worked alongside her, as illustrated below.
- 6.38 Child C's brother was seen by GP1 for minor ailments in January and on 2nd February 2011 GP1 spoke to Child C's mother over the phone about Child C's brother, and recorded that there were "family issues". GP1 arranged a same day appointment with the GP Nurse Practitioner 5 who did not record any discussion of these issues.
- 6.39 On the same day Health Visitor 2 visited and met with Child C's mother, Child C's brother and Child C's maternal grandmother. She was given an account of bullying of Child C's mother's brother at school and the emotional issues within the family. Child C's mother told Health Visitor 2 that Child C's maternal grandmother was much taken up with her difficulties with her own son and as a result Child C's mother does not feel able to talk to her about how stresses in the household are affecting her. She said she had spoken with her GP and was considering counselling. The record indicates a very adult focussed discussion and no reference to how any of this may be impacting on Child C's brother.
- 6.40 On 11th February 2011, the case was closed to the lower level CAF intervention as Children's Social Care had become involved and on 16th February a different social worker undertook another Initial Assessment. This was a very comprehensive assessment where Child C's brother was reported to be attending nursery and described as happy and always smiling. Both Child C's mother and her brother were

described as presenting as very unhappy and depressed. It is recorded that there was no contact between Child C's father and his family. The outcome of this assessment was a referral to the Adolescent Support Team for individual work with Child C's mother and her brother. An Adolescent Support Worker 1 was assigned to Child C's mother and another Adolescent Support Worker 2 to Child C's mother's brother.

- 6.41 On 28th February 2011 another notification of a domestic abuse incident was received from the police. This related to an incident when Child C's mother's brother became angry after Child C's maternal grandmother confiscated his computer when he would not go to school, misbehaved and caused damage to the home.
- 6.42 Adolescent Support Worker 1 provided intensive individual work with Child C's mother, seeing her at first weekly and then monthly from early 2011 for about 9 months. Adolescent Support Worker 1 was regularly supervised in her work by the Adolescent Team Managers, and social worker, 10, who was now the allocated Social Worker. This social worker set up group e-mails between himself, Adolescent Support Worker 1, Adolescent Support Worker 2 and Social Work Assistant 1 to ensure regular communication.
- 6.43 In May 2011, Child C's mother told Adolescent Support Worker 1 that she was stressed and exhausted and struggling to manage Child C's brother. A few days later Adolescent Support Worker 1 discussed this case in supervision. The record of this made by the team manager was that this case was 'borderline child protection' and the direction was to seek to organise a 'Family Support Meeting'. It was also recorded that Child C's mother and Child C's brother were attending 'baby groups' three times per week.
- 6.44 The focus of the work was recorded as improving Child C's mother's self-esteem and confidence. During this period Child C's mother's relationship with Child C's father was very inconsistent ;sometimes he was seeing the child and at other times reported not to be. The issue of Child C's mother's brother's behaviour was a concern and the impact that this would have on Child C's brother.
- 6.45 During April, May and June, Child C's brother was seen by a GP a few times because of eczema. The GP record shows an entry on 11th May 2011 relating to "Domestic Problems".
- 6.46 On the same day police were called, presumably by Child C's maternal grandmother, when her son, Child C's mother's brother caused damage in the home. He was interviewed in the presence of his father (Child C's maternal grandfather) and the decision was that he would stay with Child C's maternal grandfather for a few days. Police shared this information with all the usual agencies.
- 6.47 Health Visitor 2 visited later in June 2011 and found things much calmer in the absence of Child C's mother's brother. There was mention that Child C's father was a regular visitor. The Health Visitor

liaised with Children's Social Care to enquire if a date for a Family Support Meeting had been agreed but learned it had not been arranged yet.

- 6.48 Towards the end of the month Adolescent Support Worker 1 visited and was told by Child C's mother that she was depressed. She was finding Child C's brother difficult to manage. She reported that all Child C's maternal grandmother's emotional energy was focused on Child C's mother's brother even though he was not living with them, to the extent that neither the maternal grandmother nor her own brother remembered her 18th birthday.
- 6.49 The case was closed to the Adolescent Support Team as mother was now 18 and the matter assigned to Social Worker Assistant 1 to continue to support her. There was a handover period between the two social work teams to ensure that Child C's mother received continuity of care.
- 6.50 Social Work Assistant 1 said in interview that she felt she had been given sufficient information from Social Worker 10 and from an informal handover from Adolescent Support Worker 1 when fully taking over the case management. The remit given for this case was to support Child C's mother in moving out into her own accommodation.
- 6.51 On 12th July 2011 Child C's mother contacted GP 4 twice, firstly reporting that Child C's brother had ingested half an antibiotic, in the second reporting that an antidepressant tablet was missing and it was presumed by her that Child C's brother had possibly ingested it. This was dealt with medically by GP 4.
- 6.52 On 8th August 2011 Child C's mother was diagnosed with depression and treated with antidepressant medication. At that time GP 21 recorded the history of physical and emotional abuse by Child C's maternal grandfather since Child C's mother had been 2 years old.
- 6.53 On 23rd August 2011, Child C's mother and Child C's maternal grandmother became involved in a dispute with another family. The result was that C's mother assaulted an adult member of the opposing family. Child C's brother was present during the altercation. Police received several calls from witnesses and as a result attended the scene.
- 6.54 Child C's mother was arrested for assault which she admitted during interview and was given an official police caution. Officers recorded the presence of Child C's brother and checked on the child's welfare.
- 6.55 During her time in custody Child C's mother made allegations against her father (Child C's maternal grandfather) of an historical sexual assault.
- 6.56 Child C's mother became distressed and said that she hadn't seen her father since she was 14 years old because he was violent towards her.

She continued by saying that her father had sexually abused her since she was about 5 years old.

- 6.57 Police tried to clarify what Child C's mother was saying. She said that the incidents had merged in her memory and she could not remember much about them. The officer was left with the impression that there may have been two incidents. She decided that she did not wish to pursue an allegation. Children's Social Care were advised of the disclosure of historic sexual abuse.
- 6.58 In September 2011 Child C's mother is recorded as telling GP1 that she had been a victim of previous sexual abuse, perpetrated by her father (Child C's maternal grandfather) and had disclosed this because she felt other girls could be at risk. GP1 provided a supportive consultation, changed her medication and informed the HV about the nature of the consultation. GP1 understood from Child C's mother that this information had already been shared with Children's Social Care and the Police.
- 6.59 Child C's mother was supported to apply for her own housing and moved out of the family home on 18th October 2011.
- 6.60 On 18th November 2011 Child C's mother attended the GP surgery and was recorded as being back in a relationship with Child C's father and to be pregnant with Child C. On 23rd November 2011 GP 4 wrote to the community midwives advising them that there were issues contained in her records that he felt the midwives should be aware of. In this letter GP 4 asked the midwives to contact one of the GPs to discuss Child C's mother's case. On 1st December 2011 GP22 verbally summarised Child C's mother's previous history.
- 6.61 Subsequently, a booking letter was sent by the Community Midwives to the GP practice, but made no mention of having received any communication from the practice, although there is a copy of a Confirmation of Midwifery referral to Children's Social Care dated 29th December 2011 in Child C's mother's GP record.

2012

- 6.62 During the pregnancy Child C's mother saw a number of GPs and Nurse Practitioners because of a recurrence of extreme sickness. She had several hospital admissions. During the pregnancy she also had GP consultations for minor issues.
- 6.63 There is a report from Accident and Emergency at Hospital 1 dated 17th January 2012 relating to chemical burns on her arms and legs caused by an accident with caustic soda.
- 6.64 At a meeting with Social Work Assistant 1 on 26th January 2012 Child C's mother said that she had again split up with Child C's father.
- 6.65 On 1st February 2012 Social Work Assistant 1 had a supervision session with her Practice Manager and the agreed plan was to 'step down' the case to CAF, close the case to Children's Social Care, proposing the lead professional be the Health Visitor.
- 6.66 Records of the Social Work Assistant 1's visits are very focussed on Child C's mother and her relationship with her brother (Child C's mother's brother) and her mother (Child C's maternal grandmother). There are references to a rekindling of the relationship with Child C's father and then an account where she announces the relationship is finally over.
- 6.67 From April 2012 Child C's mother received support from a Children's Centre and appointed key worker, Early Years Worker 1. Discussions were recorded about what plans were in place to care for Child C's brother around the birth of Child C and issues raised by a crèche worker about Child C's brother's behaviour. A plan was put in place by the Children's Centre to support Child C's mother.

Child C's life

- 6.68 July 2012 Child C was born.
- 6.69 July 2012 Child C's mother attended the Children's Centre with Child C and it is noted that Early Years Worker 1 is considering closing the case in the future if Child C's mother and Child C's brother continue to progress according to plan.
- 6.70 The usual routine post-natal midwifery visits were undertaken. Shortly after Child C's birth the Midwifery notes say that Child C is taking a long time to feed and although Child C looks well, Child C's mother is low in mood and tearful at night.
- 6.71 A couple of days later the Early Years review records much improvement in respect of Child C's brother: '*development approaching more expected parameters*'.

- 6.72 On 30th July 2012, Health Visitor 2 undertook the new birth visit. Child C's mother reported being low in mood and options around appropriate support were given.
- 6.73 The following day at the Midwifery clinic Child C's mother is a little more buoyant; Child C's maternal grandmother is with her in a supportive capacity and, although still mentioning a low mood, is not now planning to discuss this with her GP.
- 6.74 On the same day Child C was registered at GP Practice 3. Social Work Assistant 1 visited on 1st August 2012 and Child C's mother informed her that Child C's father was planning to visit at the weekend.
- 6.75 On 6th August 2012 Child C's mother contacted Social Work Assistant 1 expressing concerns that they had seen Child C's father as planned and Child C's brother had woken that night having had a nightmare saying 'daddy hurt me'. Child C's mother said that Child C's father had shouted at Child C's brother as he thought he was going to hurt Child C. Child C's brother was not left alone with his father. Social Work Assistant 1 offered reassurance that if Child C's brother had not been left alone with his father, it was unlikely that he had hurt him, but to contact her again if the nightmares continued.
- 6.76 Child C was seen at the GP surgery twice in August 2012 because of maternal concerns about vomiting. Child C was found to have a minor tongue tie and was referred to NHS Trust 2. Child C had a normal 6 week check with GP3 where no social concerns were noted in Child C's records although social concerns were noted in Child C's mother's records.
- 6.77 On 13th August 2012 the Family Agreement was reviewed by Early Years Worker 1 who still had some suggestions to make to Child C's mother about how she might improve her interaction with Child C's brother and allow for her to spend more time with him. Child C's mother said she planned to start college shortly, so no further Family Agreement review dates was made. The implication being that the input from Early Years would cease since mother had other plans.
- 6.78 On a home visit on 15th August 2012, Child C's brother was reported to be 'happy and bubbly' and Child C's mother said that Child C's father had called round, left some money and stayed briefly. Social Work Assistant 1 discussed a Family Support Meeting to close the case and Child C's mother is reported to have indicated she was happy with this plan.
- 6.79 Sometime in the latter part of August 2012, Child C's mother began a new relationship.

Child C's Mother's Boyfriend

- 6.80 Mother's boyfriend previously lived in a neighbouring local authority area which had separate records from the local authority where Child C's mother lived. During the time period of the review and prior to his cohabitation with Child C's mother, police attended the home he shared with his then partner and their child on four occasions between the summer of 2008 and late 2009 due to domestic violence. As a result of one of these incidents the police placed a 'Treat as Urgent Marker' on the property. Following one of these occasions Child C's mother's boyfriend admitted assault on his then partner and accepted a Caution. These matters were passed to Children's Social Care in that area.
- 6.81 The neighbouring Children's Social Care Department received one anonymous referral via NSPCC with concerns being expressed regarding the neglect of their child and in relation to the relationship between Child C's mother's boyfriend and his then partner.
- 6.82 The NSPCC contact and the four domestic violence referrals were dealt with by Children's Social Care in a duty and assessment team. Enquiries were made with professionals working with the family and following these discussions Children's Social Care from the neighbouring authority decided to take no further action regarding the referrals.
- 6.83 Police and social care records show that Child C's mother's boyfriend's ex-partner (MBFX2 – see Glossary) took their child to see the GP as the child had a skin problem. He presented as fearful and when undressed he was found to have what looked like a cigarette burn and 3-4 bruises on his lower back. The mother was unable to give an explanation for the injuries. He had previous marks but Mother had previously explained their presence.
- 6.84 Children's Social Care records indicate a joint decision was made not to proceed with a Child Protection medical assessment. Whilst it was considered unusual for a child of that age to have a bruise in that location, the agreed plan was that Children's Social Care would deal with this as a single agency.
- 6.85 A social worker was allocated to the case. An Initial Assessment was undertaken but non-accidental injury was not substantiated. The case was then closed.

Child C and Events after Mother's Boyfriend Joined the Household

- 6.86 On 10th September 2012 GP 1 had a telephone consultation with Child C's mother and Child C was prescribed Gaviscon (an antacid) for reflux, a common condition of young babies. Child C had her first immunisations at the appropriate time.

- 6.87 Also on 10th September 2012 a Children's Centre worker contacted Social Work Assistant 1 by email to make her aware that Child C's mother had a new boyfriend. He was described as '*an older man who has children himself*'. The Children Centre worker said in the email '*I think we have to be wary.*' This is the first reference to Child C's mother's boyfriend.
- 6.88 Social Work Assistant 1 made her final visit to the family on 12th September 2012. Child C's mother's boyfriend was present at this visit and introduced himself. He explained that he had met Child C's mother when he came to do her hair as he was a mobile hairdresser. Enquiries were made about whether he ever stayed at the flat and he said he did occasionally.
- 6.89 Child C was described as 'happily asleep' on Child C's mother's boyfriend's lap but a small bruise was noted on the side of her head. Child C's mother explained that this had happened when they were all in bed together and Child C's brother had become excited and accidentally kicked Child C.
- 6.90 Child C's brother was noted to be sitting on the floor doing a jigsaw and was described as chatty and happy.
- 6.91 Social Work Assistant 1 made a record of her visit and recorded the bruise but did not discuss it with anyone else.
- 6.92 On 17th September 2012 a supervision record between Social Work Assistant 1 and Practice Manager records that the case was closed following on from earlier supervisory discussions. It was noted that Child C's mother was well supported. Neither the presence of a new boyfriend nor the bruise was mentioned.
- 6.93 On 21st September 2012 Child C was seen by GP 5 because of constipation. Child C's mother reported that Child C had been crying constantly.
- 6.94 On 27th September 2012 Child C's mother contacted the Children's Centre to say she would not be attending the Young Mums' Group or Stay 'n Play Plus as she is starting college.
- 6.95 On the following day Child C's mother contacted Health Visitor 2 to cancel the home visit scheduled for 1st October 2012 as she was starting college. She said a combination of Child C's maternal grandmother and friends were to look after the children on the three days she was required to attend.
- 6.96 Child C's mother visited the GP surgery on several occasions around this time for consultations but these were not considered as a whole and each viewed as an individual issue. By this time during the period covered by this review, Child C's mother had seen over 30 GPs.

- 6.97 On 5th October 2012, GP 5 spoke to Child C's mother over the phone; she reported that Child C's brother had sprayed hairspray in Child C's eyes. A same day appointment was arranged with GP6. GP6 saw and assessed Child C, he records: "*Brother sprayed hairspray in both eyes and face this morning*". GP 6 also makes a note which implies that he examined Child C's abdomen but it is not clear whether Child C was undressed for the examination. GP 6 also recorded that Child C was unable to open her eyes and he referred her to the Children's Hospital. No mention is made of safeguarding being considered.
- 6.98 Child C was seen in NHS Trust 2, Children's Accident & Emergency and then at the Eye Hospital. A thorough assessment of this unusual presentation was undertaken by the Emergency Department and Eye Hospital practitioners.
- 6.99 The 2 letters received from these consultations were processed by GP 5 who made a written entry of "Corneal Abrasion" in Child C's notes on receipt of these. No mention is made of safeguarding being considered.
- 6.100 On 11th October 2012, Health Visitor 2 visited and met Child C, Child C's brother, Child C's mother and Child C's mother's boyfriend. It became apparent that Child C's mother's boyfriend had moved in with them, and 2 of Child C's mother's boyfriend's friends were also present. Child C's mother spoke of concerns about Child C's brother's behaviour and told Health Visitor 2 of the 'hairspray' incident. Child C's mother did not think the hairspray incident was malicious but did say Child C's brother had also hit Child C with a tea towel. Health Visitor 2 gave advice about keeping dangerous materials away from children, general behaviour management strategies and the supervision of the children when together. Child C's mother told Health Visitor 2 that her boyfriend was caring for the children during the times she was at college.
- 6.101 Also on 11th October 2012, the GP surgery received a discharge report from the Speech and Language service reporting that whilst Child C's brother still had language delay, he had made good progress. On the same day Child C was seen for her second routine immunisations.
- 6.102 On 12th October 2012 Child C was reviewed at the NHS Trust 2 (Eye Hospital). The cause of the eye injury remained unresolved. No other indicators of abuse and neglect were evident. It was recorded that Child C's mother was fully compliant with the required treatment plan. It was recorded that treatment had ceased the day before and Child C was discharged back to the care of the GP.
- 6.103 On 23rd October 2012 GP 6 reviewed the discharge letter from the Eye Hospital but this did not prompt any wider considerations, despite the unusual history.
- 6.104 On 31st October 2012 Child C was seen in a local Minor Injury Unit. A report from this episode was faxed to the GP practice at 10:45am on the 1st November 2012. The report states in the history: "*head injury. Dropped by dad 0.75m from arms to table top.....*" It was recorded that

no other bruises or injuries were noted but that Child C had a firm swelling to her left temple. This report was scanned onto Child C's record on 6th November 2012 and reviewed by GP 21 on 11th November 2012. GP 21 recorded this episode as a "minor head injury". No mention is made of safeguarding being considered. Health Visitor 2 was not advised of the minor injury unit attendance.

- 6.105 Children's Social Care was only sent notification of the MIU attendance on 16th November 2012 as part of the multi-agency Rapid Response Process after Child C's death.
- 6.106 On the 6th November 2012 Child C's mother left a message on the Health Visitor telephone stating that she was concerned about Child C's brother's behaviour as he is particularly aggressive towards Child C. She stated that he 'even *hits her on the face causing bruising*'. Health Visitor 2 was not at work and her colleague, Health Visitor 3 attempted to return the call and left a message for Child C's mother.
- 6.107 Health Visitor 2 had scheduled a visit on 8th November 2012 but on 7th, Mother rang to cancel, saying she was busy with college work. She told Health Visitor 2 that Child C's brother had become increasingly violent since she started college. Health Visitor 2 gave advice about behaviour management, how changes in the family may have unsettled her son and the importance of close supervision.

Child C's Death and Subsequent Findings

- 6.108 On the 14 November 2012, Child C was taken to the Children's Hospital by ambulance having earlier been pronounced dead at the family home.
- 6.109 Child C's mother is reported to have left home at 8.45am to attend college, leaving Child C's mother's boyfriend to care for the children. Child C's mother's boyfriend states that he left Child C on the bed and covered her head with a blanket, which both Child C's mother and Child C's mother's boyfriend reported they usually did while she slept. He discovered her not breathing at 11.45am and called an ambulance.
- 6.110 On examination, Child C was found to have superficial blisters on her left ear and neck and at the back of her scalp. These were later identified as being possibly due to impetigo, a common childhood skin infection often caused by the bacterium *Staphylococcus aureus*, which was grown from the blisters.
- 6.111 The forensic post mortem did not find any natural causes likely to have caused death.

- 6.112 Bruising was also found on Child C's scalp which was likely to have been a few days old. No explanation was given before the death. When Child C's mother was spoken with in October 2013 by the Overview Author, she said these bruises were brought to her attention by her boyfriend, some days before Child C's death. She reports he said Child C's brother had caused the injuries by throwing coins at Child C.
- 6.113 Child C's death is given as 'of unascertained causes' by the Coroner.
- 6.114 Police intelligence records dating from 2006 searched after the death of Child C regarding the background of Child C's mother's boyfriend showed that he was known to both police and Children's Social Care in a neighbouring authority, but under a different name. This police intelligence records that complaints were received that Child C's mother's boyfriend had been engaging in sexual activity with underage girls. The police records show that this intelligence was passed to an experienced child protection detective. There is no record of the outcome. The same man was questioned in connection with drug offences in the area. This information would have been available to any agency who had requested it. The information was cross-referenced in police data against both names.

7. Analysis and Emerging Themes

7.1 Theme 1 - Focus on the Child

- 7.1.1 Keeping a strong focus on the outcomes intended for children is essential to deliver a child-focussed approach. Being able to respond promptly and confidently to safeguarding concerns is an essential requisite to maintain a child focussed approach.
- 7.1.2 Throughout the Individual Organisation Review reports there emerges a picture of Child C's mother as vulnerable and in need of support. She was still a child herself when she became a mother and at that point it seems welfare agencies began seeing her as a mother first and child second.
- 7.1.3 There is a tendency for child welfare practitioners to focus on the adult account in assessments and often, as a study by Holland¹¹ reported, '*children tended to be excluded or marginalised in favour of engagement of parents in the assessment process*'. The Assessment of Children In Need and Their Families¹² requires for each child's needs to be individually assessed as well as the parents capacity to meet those needs.

¹¹ S Holland Child & Family Assessment in Social Work Practice 2004

¹² Framework for the Assessment of Children In Need and Their Families HMSO 2000

Children Who Become Pregnant

- 7.1.4 Child C's mother became pregnant for the first time aged fifteen. This in itself was a significant risk factor. She was further vulnerable as a result of her family experiences of family violence and inconsistent parenting. Home Education may well have had an impact on how her independence and autonomy developed.
- 7.1.5 At the point she became an adult Children's Social Care continued a sustained period of involvement, though the approach did not take sufficient account of Child C's mother's status as a child or her capacity to become independent.
- 7.1.6 Following the birth of Child C's brother the intention may have been to focus on him (Child C was not yet born), but the emphasis was on Child C's mother, her self-esteem, coping ability and general level of independence.
- 7.1.7 A fresh Social Care assessment was certainly required at this point in order to fundamentally re-assess the circumstances, taking into account Child C's mother's dual status as both child and mother and Child C's brother similarly as a Child In Need.

Focus on Children and Avoiding being Distracted by Adult Issues

- 7.1.8 There are few practitioners who would not accept the importance of working to boost the strengths and resources of parents and families, including those in most need of support, to make situations safer and healthier for children. In this case the focus was too much towards the adults, there is little note in Children's Social Care records of references to Child C's brother. The response was most frequently influenced by the need which seemed most urgent.
- 7.1.9 The children's circumstances were rarely mentioned within the Children's Social Care case record, other than in relation to Child C's mother. It is not unusual for the overwhelming needs of vulnerable parents to readily be the focus of attention for child welfare practitioners. This is reflected in many inquiry reports.
- 7.1.10 The Practice Manager indicated in February 2012 that the case should close in Children's Social Care. However, it was kept open, because Child C's mother was unwell, even though there was a perception that there was pressure to close cases.
- 7.1.11 The Social Work Assistant who was the case manager assumed a specific brief of supporting Child C's mother into independence.

7.1.12 In Children's Social Care safeguarding had been discussed in a supervision session between Adolescent Support Worker 1 and the team manager in May 2011. The comment that this was '*borderline child protection*' seems to have been mitigated by the acknowledgment of services being received and a plan to hold a Family Support Meeting. The children's circumstances were, for most of the time, viewed as a 'low level Child In Need'. In Children's Social Care the focus of intervention should be on providing assessments of children's circumstances and providing access to services to improve children's circumstances. There was insufficient clarity in the social care intervention about who was the 'client'. Child C's mother's clear vulnerabilities overshadowed the requirement from the time Child C's mother became an adult, to keep a focus on the child. In Children's Social Care planning, the child should unequivocally be at the centre and the focus of any intervention.

7.1.13 During the early months of 2012 the Social Care plan was to close the case and step down the intervention to a CAF level despite the prevailing and emerging risk factors. The important point to make here is that the prevailing vulnerabilities of Child C and other emerging risk factors should have raised levels of intervention rather than diminish them. The arrival of a second baby to a teenage mother, a new man in the family and mother's plan to return to education were indicators that this required allocation to a qualified social worker and re-assessment of the children's circumstances, in order to inform a multi-agency plan to support the family.

**Theme 1
Learning Point**

(1) The focus of all agencies working with children should always be the child

**Theme 1
Recommendations**

- (1) Children who become mothers and fathers should be considered by all agencies as children first and their particular vulnerabilities and service requirements addressed from that perspective. Both new child and under 18 parents are potentially children in need.**
- (2) The focus of attention should always be the child. Where agencies provide services to both children and adults, separate but related records should be generated**
- (3) Reflective and challenging Supervision is key for front line practitioners in ensuring the focus of interventions is on the child.**

7.2 Theme 2 - Incidents/Injuries sustained by a non-mobile child

7.2.1 Injury 1 on 12th September 2012

7.2.2 During a visit to Child C's home where Child C's mother and her new boyfriend were present, Social Work Assistant 1 discussed a small bruise on the side of Child C's head. Child C's mother explained this was caused accidentally by Child C's brother kicking her excitedly when they were all in bed together. This appears an unlikely cause and effect but required further consideration and investigation. Social Work Assistant 1 accepted the explanation and did not think it sufficiently unusual to advise her manager or think about the possibility of seeking advice from a paediatrician.

7.2.3 Injury 2 on 5th October 2012

7.2.4 Child C was taken to the GP by her mother with eye injuries said to have been caused by the accidental spraying of hairspray. The GP referred immediately to NHS Trust 2 and she attended Children's A&E and the Eye Hospital. (see para 7.99 -7.104 for details).

7.2.5 This was a relatively unusual presentation for a baby. Child C was assessed by a Paediatric Emergency Nurse Practitioner and Eye Hospital specialist doctor. The Individual Organisation Review author noted *'Further information was gained through a conversation with the Paediatric Emergency Nurse Practitioner who assessed the baby in the Children Emergency Department. Emergency Nurse Practitioner remembers thinking that the mother may have 'jumped to the wrong conclusion' that the baby's red eyes were as the result of the sibling spraying hairspray into the baby's eyes'*.

7.2.6 The Emergency Nurse Practitioner had established that Child C's mother had concerns about her elder son's jealous behaviour of the baby, had found a can of hairspray under his bed and according to mother the 3 year old had said he had sprayed some on the baby. The Emergency Nurse Practitioner sent a discharge fax to Health Visitor 2 including information that Child C's mother was concerned about Child C's brother's jealousy towards Child C. This was acted on by Health Visitor 2 but telephone liaison following this unusual incident may have been more appropriate.

7.2.7 Best practice would have also been for the Emergency Nurse Practitioner and Eye Hospital practitioners to have considered whether the explanation was reasonable as to whether a child just over 3 years could have the dexterity to depress and effectively aim a hairspray. They should also have considered

whether a 3 year old would have the emotional or cognitive development to make the decision to do so in relation to sibling jealousy. Mary Sheridan's ¹³ Child Development Matrix seems to indicate that such fine motor skills would be unlikely to be present in a child aged less than 5 years.

- 7.2.8 If the likelihood or otherwise of Child C's brother causing the injury had been reflected upon, then consideration may have been given to the possibility that another person caused the eye problem.
- 7.2.9 The Paediatric Emergency Nurse Practitioner thought it was more likely that the 'red eyes' were a result of infection, rather than chemical injury. Findings were not conclusive and further assessment at the Eye Hospital was requested. The Paediatric Emergency Nurse Practitioner also recalls in the verbal hand over to the Eye Hospital emergency department that if a chemical injury was confirmed further support would be needed from the Health Visitor. Best practice would have been for the Emergency Nurse Practitioner and Eye Hospital practitioners to have considered both explanations as potential causes.
- 7.2.10 Further exploration with the Emergency Nurse Practitioner during the course of the Individual Organisation Review confirmed that at this stage she did not have any safeguarding concerns but thought that support from the Health Visitor may be required in helping mother to manage her son's challenging behaviour if a chemical injury was confirmed. There were no other 'triggers' in the presentation which caused the Emergency Nurse Practitioner any concern.
- 7.2.11 The above story is at variance with the account provided to the Author at a meeting with Child C's Mother in October 2013. At this point she said she returned home and her boyfriend brought to her attention a 'crusty' residue around Child C's eyes and said he believed the elder child had sprayed hairspray in her face. His evidence for this was, he said, the discovery of a hairspray canister under the boy's bed.
- 7.2.12 Best practice would have been for practitioners at the Eye Hospital to have communicated back to practitioners in the Children's Emergency Department or directly to the Health Visitor if this was considered as a possible cause at the time of the incident. Child C's mother's possible history of the incident was accepted by the Eye Hospital staff although the likelihood of an infection was favoured by the Emergency Nurse Practitioner at the Children's Emergency Department.

¹³ Reports on Public Health and Medical Subjects No 102HMSO 1975 referred in Framework for Assessment of Children in need and their Families. HMSO 2000

- 7.2.13 Best practice would have been for the Emergency Nurse Practitioner and the Eye Hospital practitioners to keep both explanations as potential causes and to have liaised with Health Visitor 2 to discuss the possibility of the hairspray being the cause given that this was the explanation that Child C's mother herself felt was the cause of the 'sticky' eyes.
- 7.2.14 In summary what happened to Child C's eyes is unknown. There were bilateral corneal abrasions and though different explanations have been suggested, it is unclear what actually caused the small amount of corneal damage. Child C's eyes recovered.
- 7.2.15 No communication back to the Children's Emergency Department from the Eye Hospital occurred after the corneal abrasions were noted. The possibility of an inflicted injury was not considered by the practitioners in either location caring for Child C. The explanation of the hairspray was not considered causal by the Emergency Nurse Practitioner at the Children's Emergency Department and infection was thought to be more likely.
- 7.2.16 Discharge information was sent from the Children's Emergency Department to both GP and Health Visitor 2 which included information regarding the jealous behaviour of the Child C's brother. This was acted upon by Health Visitor 2 at her next home visit.
- 7.2.17 Mother kept all the follow-up visits at the Eye Hospital.
- 7.2.18 **Injury 3 was reported 31st October 2012.**
- 7.2.19 Child C's mother had been at college and returned home immediately noticing an 'egg-sized' swelling on Child C's forehead. Child C's mother's boyfriend said he had dropped her and explained this in the context of a weak left arm due to epilepsy. Child C's mother said during conversation as part of his Serious Case Review, that she insisted on seeking medical advice and so attended the Minor Injuries Unit accompanied by Child C's mother's boyfriend.
- 7.2.20 The Minor Injuries Unit was very quiet. There were no patients being treated and none waiting. Those on duty included two Emergency Nurse Practitioners, one with Paediatric specialism and a Registered Nurse.
- 7.2.21 Emergency Nurse Practitioner 1, who saw Child C, is an adult trained nurse but, within the Minor Injuries Unit, there is an expectation that clinicians work across the age groups. The Emergency Nurse Practitioner selected Child C from the screen which was described by the receptionist as 'baby, bumped head'. Emergency Nurse Practitioner 1 went to the waiting area

to greet the family. The case was not triaged by the Registered Nurse contrary to usual practice.

7.2.22 Emergency Nurse Practitioner 1 reported undertaking a thorough physical examination and asking a range of standard questions. Both Child C's mother and her boyfriend denied any history of social work involvement and did not reveal the previous medical history (eye incident) in respect of Child C.

7.2.23 Emergency Nurse Practitioner 1 confirmed the mother was Child C's mother but assumed Child C's mother's boyfriend to be the father. During interviews held with the Serious Case Review Overview Author as part of the Serious Case Review process, Emergency Nurse Practitioner 1 recalls thinking the couple were relaxed and behaving normally. Child C presented well: 'happy and chirpy'.

7.2.24 Emergency Nurse Practitioner 1 recorded a description of the child being dropped 0.75 metres from Child C's mother's boyfriend arms onto a table.

7.2.25 *Munro (2008) provides a scenario(p141) where a seeming coherent account provided by a carer must be considered cautiously from all angles but that plausibility can really only be confirmed by checks with other agencies: 'The difficulty, in practice, is to decide how long to go on checking and when to accept or not accept what seems, on the surface, a plausible account'.¹⁴*

7.2.26 Information about this attendance by Child C was not passed to the Health Visitor but it was sent to the GP. The usual expectation was that letters for both the GP and Health Visitor would be placed in the same envelope and received by each. If this information had been brought to Health Visitor 2's attention she would have had the opportunity to consider this in the light of the recent eye injury.

7.2.27 In this case, the records show that timely communication was sent to the GP but not received by the Health Visitor. Normal practice would be to send the information to both GP and Health Visitor. The Overview author is aware that the local NHS Trust regularly audits the transfer of information from the MIU to the GP and Health Visitor. In this case the Health Visitor was not alerted but the GP was.

7.2.28 During the Serious Case review separate concerns were raised by a member of NHS staff who had already been interviewed. These were seen by the Independent Review Author who was satisfied that they did not introduce any new information and

¹⁴ E Munro. Effective Child Protection 2nd edition 2008

were already being dealt with through an appropriate separate process.

7.2.29 Injury 4 was reported on 6th November 2012.

7.2.30 This is the injury reported by Child C's mother in an answer-phone message to Health Visitor 2. She said Child C's brother was hitting Child C and even bruising her face. Health Visitor 2 was not in the office but Health Visitor 3 attempted to telephone Child C's mother and left a message. The following day Health Visitor 2 gave advice that Child C's mother should ensure that she supervises closely when the children are together. Health Visitor 2 expected to see Child C within the next 2 days but Child C's mother cancelled the appointment.

7.2.31 Incident/Injury 5 on 14th November 2012.

7.2.32 This is the incident which resulted in Child C's death and is described in detail elsewhere in this report.

7.2.33 Injury 6 post mortem.

7.2.34 Bruising to Child C's scalp was noted following her death and has no explanation.

7.2.35 **Injuries to non-mobile babies are rare:** 'Bruising in babies who are not independently mobile is very uncommon (under 1%). Around 17% of infants who are crawling or cruising have bruises, whereas the majority of preschool and school children have accidental bruises. Bruising in a baby who is not yet crawling, and therefore has no independent mobility, is very unusual.¹⁵

7.2.36 Research recently published in the USA¹⁶ involving 401 non mobile babies with injuries found that 200 were substantiated as abused with 27.5% of these having been seen previously with bruising. The unsurprising conclusions were that in non-mobile babies there are often 'sentinel' or warning injuries leading to more serious injury. The advice to clinicians resulting from the research was to be alive to implausible explanations and to be prepared to think the unthinkable.

¹⁵ Core Info Child Protection Systemic Reviews

¹⁶ Dr Lynn Sheets, Professor of Paediatrics, Medical College of Wisconsin

Theme 2

Learning Points

The presence of injuries or incidents in non-mobile infants should always be considered in the context of safeguarding.

- (1) A bruise should never be interpreted in isolation and must always be assessed in the context of the child's medical and social history, developmental stage and explanation given. The presentation of a bruise in a non-mobile infant, whilst appearing fairly minor in itself, may indicate more serious internal injuries and may have a non-accidental cause. It may also be a precursor for further injuries. A series of injuries in a non-mobile infant should set alarm bells ringing.**
- (2) Any injury or unusual presentation in a non-mobile infant should be seen promptly by a clinician experienced and trained in examining small infants. Inflicted and neglectful causes must always be considered in the differential diagnosis, even if an accidental explanation is very plausible. Discussion with a health professional experienced in safeguarding, and multi-agency safeguarding enquiries should *always* be considered and discussion documented. If no discussion takes place the reason for this should also be documented. Respectful uncertainty and professional curiosity are the guiding principles here. 'Those who don't cruise, rarely bruise'¹⁷ NICE Clinical Guidance¹⁸ provides practitioners alerting features of child maltreatment including advising that bruising to babies who are not independently mobile should raise suspicion.**
- (3) The post mortem examination did not determine a clear reason for Child C's death. Nevertheless, there was a pattern of 'sentinel', or warning injuries (see paragraph 7.2.34 above) which occurred during a very short timescale which should have been investigated in a broader safeguarding context. The first was noted on 12th September and there were others over a period of 8 weeks prior to Child C's death on 14th November 2012.**

Theme 2

Recommendations

- (1) A multi-agency protocol should be developed in relation to the management of injuries (incidents) concerning non-mobile babies.**
- (2) The South West Safeguarding Procedures should be revised to reflect current research about injuries. Consideration should be given to including the local multi-agency protocol (above).**
- (3) The phrase 'Children Who Don't Cruise Rarely Bruise' should be adopted as a multi-agency guide when professionals are considering injuries or unusual presentations in non-mobile babies**

¹⁷ Core Info Cardiff Child Protection Systemic Review

¹⁸ NICE Clinical Guidance revised December 2009

7.3 Theme 3 - The Invisibility of Men

- 7.3.1 The 'invisibility' of significant men in this family system is notable but not unusual. The welfare agencies knew very little about Child C's maternal grandfather, Child C's father or Child C's mother's boyfriend and it seems little attention was focussed upon them. Their importance to the functioning of the wider family cannot be over-estimated and the role of fathers or father-figures particularly.
- 7.3.2 The Children's Social Care Individual Organisation Review author notes there were numerous opportunities for Children's Social Care to gain a greater insight into the role of Child C and Child C's brother's father in this family during the course of '*a series of Initial Assessments, particularly at the time he had sole care of Child C's brother during the period Child C's mother was ill in hospital. This did not happen during any of the Initial Assessments or Social Work Assistant 1's work with the family*'.
- 7.3.3 Since 2004 the UK Government has stated its intention to 'support a cultural shift in all service provision to include fathers in all aspects of a child's well-being'¹⁹. The National Service Framework for Children, Young People and Maternity Services (NSF) states: 'The role of fathers in the parenting of their children is frequently overlooked', it goes on to say why this is important for the child's development.
- 7.3.4 The failure to recognise the relevance of male figures and engage them in assessment has been recognised as a significant shortcoming. The Serious Case Review into the death of Peter Connelly and other high profile Serious Case Reviews nationally includes similar failings in not being sufficiently questioning of males in families and missing the opportunity to identify who they are.
- 7.3.5 The increasing volume of research on the impact of fatherhood reflects not only on the important role men play in their children's lives but the negative impact on children of effectively excluding them.
- 7.3.6 Action For Children²⁰ make the point: '*Too often significant male figures remain invisible within the safeguarding process. Agencies do not seek information which may prove vital in order to identify both protective and risk factors*'.

¹⁹ DOH & DFS 2004:70

²⁰ Action For Children 2009. Working with Fathers and Male Carers

- 7.3.7 A Department For Education review of the inclusion of male figures in services found that local authorities were at best 'neutral' with regard to men and fathers. *'Father inclusive practice was not seen as routine or mainstream in family services'*²¹.
- 7.3.8 A culture where men's role within and around families is seen and recognised is required to be more widely embedded. The positive association of father figures in the professional's mind and recognition of that importance is more likely to lead to a circumstance where visiting practitioners will naturally enquire about the role of men within families, their experience of parenting, involving them in assessment and asking the sort of questions they may ask mothers.
- 7.3.9 If this attitude was more prevalent it would more likely to have led to a natural questioning of Child C's mother's boyfriend and his role in this family and identifying information.
- 7.3.10 Professionals did not sufficiently consider the connection between the arrival of Mother's boyfriend in the family and the reported challenging behaviour by Child C's brother and injuries to Child C.
- 7.3.11 Although little is known of Child C's mother's boyfriend, he was a man with little experience of caring directly for children according to the neighbouring authorities records and suddenly he was caring single-handedly for two. There had been questions asked about the child care arrangements for the children whilst Child C's mother was attending college but initially this was understood to be provided by Child C's maternal grandmother and friends. It was not until it was happening did the Health Visitor learn that the child care was being provided exclusively by Child C's mother's boyfriend. This was, potentially, an opportunity to make further enquiries around his parenting experience.
- 7.3.12 With hindsight we know that injuries to Child C all happened following the arrival of Child C's mother's boyfriend in the family. The first injury was allegedly witnessed by Child C's mother but all the following injuries and the circumstances leading immediately to Child C's death occurred during her absence and during times Child C's mother's boyfriend was sole carer.
- 7.3.13 At the point three practitioners from different agencies learned of the presence in the household of a new man there was insufficient unease to generate an enquiry to police. Child C's mother's boyfriend was an unknown factor and practitioners did not ask him about his identity or background which would have

²¹ Page J and G Whitting. A Review of How Fathers can be Better Recognised and Supported through DCSF Policy 2008

been required to make enquiries of the police. This could have happened if any of the three known injuries during those weeks had caused sufficient reflection to warrant a discussion between agencies in the context of safeguarding. An awareness of the unusualness of accidental injury in a non-mobile baby would have caused this to be considered differently. At that point, if Child C's mother's boyfriend's name and date of birth were known and confirmed, a check by police would have revealed the Bristol based information about domestic violence and the later suspicious injuries to Child C's mother's boyfriend's child 2. Such an enquiry, based initially on background checks with other agencies, would have exposed a pattern of injury and other factors which should have been considered and weighed up in a multi-agency strategy discussion and possibly a child protection conference.

7.3.14 There is a lack of clarity, certainly from social care perspective, about the threshold for information sharing by police, outside of a formal section 47 (child protection) enquiry.

Theme 3

Learning Point

- (1) Fathers and significant male figures should always be fully included in assessments. New men joining families should always be engaged by professionals and their backgrounds researched and details recorded.**

Theme 3

Recommendations

- (1) Clarity is required between police and other agencies about the circumstances under which police can share information outside of sec 47 of the Children Act 1989.**
- (2) Fathers and partners should be fully considered and involved in assessments of need. LSCB should promote the Engaging Fathers Programme and consult with other Authorities who have successfully engaged fathers.**
- (3) A thorough consideration of significant others who join families or become involved in the life of children of that family needs to be emphasised as a factor in multi-agency assessments**

7.4 Theme 4 - The Rule of Optimism, Drift and Lack of Continuity of Care

- 7.4.1 Between 2008 and late 2012 Child C's mother saw over 30 GPs. The author of the Primary Care Individual Organisation Review noted '*Throughout the period of the review the majority of primary care staff viewed members of the family in isolation to each other without placing in context the impact of factors intrinsic to either Child C's mother, Child C's father, Child C's Brother or Child C on each other*'.
- 7.4.2 The GPs and allied staff only seemed to hold a partial view and each presentation was essentially considered in isolation. The emotional and social context of Child C's mother's presentations was rarely considered, and safeguarding, seemingly, only by two of the GPs. GP15 considered the injury to Child C's brother at 6 months as potentially non accidental and liaised with the health visitor. The same GP saw past the medical presentations of Child C's mother and considered emotional origins of symptoms. As a result of Child C's mother speaking of threats from Child C's father's family GP15 made a safeguarding referral.
- 7.4.3 According to the Children's Social Care Individual Organisation Review author there was an extensive and competent assessment completed by Social Worker 9 in September 2011.
- 7.4.4 When the case was held in the Adolescent team there was good communication within Children's Social Care. Soon after the case transferred to Social Work Assistant 1. It is the practice in South Gloucestershire Children's Social Care for social work assistants to case manage Child In Need cases under the supervision of a Practice Manager. At interview the Practice Manager confirmed these arrangements and emphasised they do not undertake assessments.
- 7.4.5 In an increasing number of local authorities there is a move away from less qualified staff being case managers. The implication for doing otherwise, as illustrated in the case, is that major changes in a family's circumstances remain unassessed. To emphasise the point: during the period of Social Work Assistant 1 allocation a teenager becomes pregnant for the second time, separated from the father of the expected baby, gives birth to the baby, is suffering depression, starts a new relationship, the baby is injured; she plans to attend college; children are to be left in the care of an unknown male: none of which was formulated in an updated assessment.

- 7.4.6 There is not a straightforward link to demonstrate that good assessment leads to good outcomes for children; there is evidence to show that inadequate assessments are associated with worse outcomes²². Similarly, poor and incomplete assessments are a feature in Serious Case Reviews²³.
- 7.4.7 The plan articulated by Children's Social Care was to withdraw from the case because the family's needs could readily be met through the lower level multi-agency Child Assessment Framework (CAF) process. This was the plan but what happened was withdrawal by Children's Social Care and no action with regard to CAF.
- 7.4.8 The theme running through this case from Children's Social Care perspective was that, contrary to most of the evidence, Child C's mother was 'doing well'. Her circumstances included being a very young mother from a troubled background, a frequent visitor to her GP, including receiving treatment for depression.
- 7.4.9 Fundamentally agencies have the responsibility for ensuring a work environment which contributes to good critical reasoning. Whether this is in a busy GP surgery or Social Care office. In order to minimise such tragedy which is the focus of this Serious Case Review, sufficient time needs to be provided to think, whilst accepting errors will occur. Within the system there needs to be mechanism for correcting error. Often this mechanism will be reflective supervision.
- 7.4.10 There were some real impacts on Social Work Assistant 1 at this time: she had significant life events outside her employment; and she was working very closely with a very traumatic case. Social Work Assistant 1 said at interview that she spent much time outside her normal working hours attending to issues related to this case.
- 7.4.11 Whilst Social Work Assistant 1 says she was well supported by colleagues and managers, it is clear that these events and their aftermath had a marked impact upon her.
- 7.4.12 There were some moments where a more curious professional response and professional conversation with a colleague may have led to a different outcome, whether that be about injuries or the identity of Child C's mother's boyfriend. Child C was only ever seen as 'at risk' from her brother and where this was known, professional advice was given.

²² FauthR, Jellic H, Hart D, Burton S, Shemmings D, Bergerac C, White K 2010 Effective Practice to Protect Children Living in Highly Resistant Families

²³ Rose W, Barnes J 2008 Improving Practice: A Study of SCR 2001-3

7.4.13 Child C's mother was seen by a range of professionals as a vulnerable young woman and provided a wide range of services in addition to those universal services. Throughout Child C's brief life there was no real consideration of any child protection measures being required.

7.4.14 The presence of Child C's maternal grandmother alongside Child C's mother at meetings with professionals was too readily seen as a positive support without question. This despite Child C's mother's comments to the contrary and the knowledge that the maternal grandmother was substantially preoccupied by her son (Child C's uncle, mother's brother) and the demands of his behaviour.

7.4.15 A rule of optimism pervaded the management of this case in most quarters. Paradoxically, considerable energy from helping agencies is devoted to planning for independence for teenagers when in fact the young people concerned are well behind in their emotional and social development. The impact of Child C's mother's history and circumstances were readily put to one side in the light of any perceived positive element: so she was seen to be 'doing very well', and that meant support services could be withdrawn. Such snapshot observations were not the result of multi-agency assessment. There were some signs which led to this positive perspective, but mostly these could be equally read as negatives. It seems that the factors of running her own home and returning to education neutralised the other factors known about Child C's mother: her emotional frailty over many years, her young age and the demands of two small children.

Theme 4

Learning Points

- (1) Vulnerable families should be allocated to a single nominated GP and effort should be made to direct consultation appointments towards this GP so as to maintain consistency and consider presenting information in the family context.**
- (2) Assessment is a continual social work task and not a single event. Assessments should be updated, particularly where significant changes occur in a family's circumstances.**

Theme 4

Recommendation

- (1) Before a child's case is closed in Children's Social Care a reflective supervision is recorded on the child's file which includes not only positive factors but also a list of risk factors**

7.5 Theme 5 - Silo Working

- 7.5.1 The Individual Organisation Review prepared by Survive comments that Team Around the Family arrangements were not robust in South Gloucestershire at the time. Meetings of professionals to share assessments and plan multi-disciplinary interventions were rare. The seeming partial information held by individual agencies easily influenced incomplete and skewed perspectives. This is all the more perplexing since many of the key agencies were co-located. On further enquiry it became apparent that although some critical agencies were co-located this did not lead to closer working together. The co-located agencies had separate reception arrangements, separate telephony and separate IT. Co-location does not in itself necessarily lead to closer working together. The implications here are that it didn't, even though this may have been the aspiration.
- 7.5.2 In May 2011 there was discussion over a couple of months for the need to arrange a Family Support Meeting; this never seems to have happened.
- 7.5.3 There is a theme throughout the Individual Organisation Reviews and chronology of different professionals gaining an often contradictory view of exactly how well Child C's mother was managing. Throughout the timeframe covered by this Serious Case Review, Child C's mother visited the GP many times more than the average for her age but this was not recognised during those times.
- 7.5.4 Agency resources have an impact on the ability of services to effectively undertake their role. Munro²⁴ makes strong statements about this often ignored element within the child protective system: 'Do staff have the resources needed to work to a good level?' Social Work Assistant 1 was involved with Child C's mother and her children during the first half of 2012. There had been some turbulence in the team but that was a full year before when 3 social workers left in quick succession; and a restructure, merging two social work teams was undertaken. Such turbulence can have an impact going forward on staff morale and staff in the team mentioned this when interviewed. There were up to 7 social worker vacancies around this period but they were filled by agency staff. Social Work Assistant 1 was not a qualified social worker and although very experienced had not undertaken up to date child protection training.

²⁴ E Munro – Effective Child Protection 2nd Edition 2008

- 7.5.5 Experience on its own is not sufficient and is required to be linked to reflection. Michael Oakshott²⁵ focuses on the limitations of circumstances in *'.. a crowded life where people are continually occupied and engaged but have no time to stand back and think. A working life given over to distracted involvement does not allow for the integration of experience.'*
- 7.5.6 There was confusion from Midwifery about whether Child C's mother's family had an allocated social worker. When asked by the Midwife Child C mother said she had a social worker. This may have falsely assured midwives. At the time of Child C's birth when a social work assistant was supporting the family, this role was not fully understood and was in fact described as a Family Support Worker.
- 7.5.7 The Early Years Individual Organisation Review writer was of the view that agencies worked well together but there was recognition that EW1 was concerned about the presence of Child C's mother's boyfriend but didn't have the confidence to challenge Social Work Assistant 1 about the concerns or escalate this.
- 7.5.8 Risk factors were not identified and during the time things were becoming more risky for Child C, a plan decided upon at a much earlier time was executed by Children's Social Care without a current assessment. The only agencies actively involved were from universal services. Children's Social Care closed the case as did Early Years.
- 7.5.9 Child C and her brother were being supported by Children's Social Care as Children In Need (as defined in Section 17 Children Act 1989) and as such should have been subject to a Child In Need Plan and multi-agency Child In Need Reviews where information would have been shared with mother and between agencies.
- 7.5.10 Child C, Child C's mother and Child C's brother were visible to a large range of agencies and within them a large number of professionals. Child C's mother saw over 30 GPs during the 4 year period of this review and 12 Children's Social Care workers. The result was that there was little insight into the family's functioning. The information that was available was not wholly shared. Early Years, for example, knew nothing of mother's family history; the various GPs tended to view each consultation in isolation. There was one assessment by Children's Social Care described as 'detailed' but this was an Initial, rather than a Core Assessment.

²⁵ M Oakshott The Voice of Liberal Learning 2001

**Theme 5
Recommendations**

- (1) CIN cases should be subject to multi-agency Child in Need reviews**
(2) All agencies should present case chronologies to CIN reviews

8. Conclusions and Final Remarks

- 8.1 This is a case where there is a complex family history which wasn't fully brought into focus by the agencies involved. This lack of a full and clear, shared picture meant that each agency only had a partial account. That said, the issues around the untimely death of Child C are, with hindsight, more straightforward. There were a series of events which if fully appreciated may have provided a better informed approach. The post mortem was not able to establish the cause of Child C's death. This SCR is, therefore, not able to comment on whether the child's death was either predictable or preventable.
- 8.2 Despite the increasing demands on a young single parent, having one child and then a second, suffering depression, having little emotional resources to support her, the contrasting professional theme was that Child C's mother was doing well. The increasing GP consultations were not viewed in an overall context but were mostly seen as individual presentations. Those in regular contact with Child C's mother misread the signs and in fact sometimes these signs were too readily interpreted as positives or as signs of her independence.
- 8.3 Child C's mother was well 'known' to caring agencies during her transition from childhood to adulthood. At the moment she became pregnant, though still a child, the attitude of professionals effectively switched to view her as a mother, rather than a child who was to become a mother. Much of the intervention was focussed on Child C's mother and her capacity to parent and to become independent, with less than equitable focus on her children and their lives.
- 8.4 Child C suffered a series of injuries over an eight week period and these were not fully known across the professional network. The GP practice received communication about the two incidents (injury 2 and 3) but critically, the Health Visitor was not advised of injury 3. The significance of the first 'sentinel' (warning) injury was not recognised by the professional who first noted it. All the injuries were viewed individually and not considered in the wider context.
- 8.5 The three significant men within the wider family were not drawn into any assessment of the family's functioning and still remain, essentially, unknown.

- 8.6 The significance of injuries to non-mobile babies was not appreciated by the professionals to whom Child C was presented. Safeguarding was not considered and reflected upon. Practitioners were too ready to accept the carer's explanation for injuries that were sustained by Child C without sufficient enquiry or reflection. The watchwords of Lord Laming: '*respectful scepticism*' were not in practitioners' minds when faced with injury to Child C.
- 8.7 In this case there were a number of connected themes which included fragmented practice, a lack of holistic assessment, multi-agency review and professional challenge. These factors undermined the potential to provide a more robust safeguarding response to Child C and her family.

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2. S Maguire, M Mann, J Sibert, and A Kemp. Are there patterns of bruising in childhood which are diagnostic or suggestive of abuse? A systematic review
3. NICE guideline When to Suspect Child Maltreatment (Clinical Guideline 89, July 2009) states that bruising in any child not independently mobile should prompt suspicion of maltreatment. See:
4. <http://guidance.nice.org.uk/CG89/QuickRefGuide/pdf/English>.
5. There is a substantial and well-founded research base on the significance of bruising in children. See <http://www.core-info.cf.ac.uk/bruising>.
6. Bruising Protocols Wessex LMC 2013
7. E Munro Progress Report – Moving to a Child-Centred System 2012
8. E Munro. Effective Child Protection 2nd edition 2008
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10. R Dazell & E Sawyer. Putting Analysis into Assessment NCB 2007
11. Mary Sheridan Child Development matrix referenced in Framework for Assessing Children in Need and Their Families. DOH 2000
12. S Holland. Child & Family Assessment in Social Work Practice 2004
13. Arch Dis Child. 2005 February; 90(2): 182–186.

Recommendations Made in Individual Organisation Reviews of Contribution Agencies

1. NHS Trust 1

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
Ensure lessons learned from reflective practice session in MIU are implemented as changes in practice	Develop action plan Audit action plan via annual MIU records audit	Lead Emergency Nurse Practitioner MIU (supported by Named Nurse)	Can be achieved within current provision	Immediate and audit by March 2014	<p>Action plan developed and shared with all staff, September 2012.</p> <p>Learning shared with ED department in Frenchay and Southmead MIU at Level 3 Child Protection training commencing 27/02/14</p> <p>Audit carried out Feb 2014 to ensure learning and changes in practice are embedded.</p> <p>Audit report shared with NBT Safeguarding Children Operational Group and Sirona Health.</p>

<p>Protocols to be developed regarding Information Sharing where there are new partners in household where there are vulnerability factors or present or previous CSC involvement</p>	<p>Included in level 3 child protection training</p> <p>Include in briefing note sent out by Safeguarding Children Team</p> <p>Include in review of Child Protection Policy</p>	<p>Named Professionals</p>	<p>Can be achieved within current provision</p>	<p>August 2014</p>	<p>Included in Level 3 Child Protection training</p> <p>Included in Safeguarding Children briefing to HVs and SHNs July 2013.</p> <p>Include in Child Protection Policy when reviewed August 2014</p>
<p>North Bristol NHS Trust to develop clear protocol regarding bruising in non-mobile babies</p>	<p>As above</p>	<p>Named Professionals</p>	<p>Can be achieved within current provision</p>	<p>August 2014</p>	<p>Task and finish group - 23/02/14 lead by Designated Doctor to include UHB and NBT Named Professional's and other representatives. This action is now wider than NBT and included in Overview Actions</p>

2. NHS Trust 2

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
For midwives to record detailed information about the father of unborn and to identify potential safeguarding risks antenatally	Targeted single agency training and reinforcement of this key message through midwifery supervision	Named Midwife for UHB/Midwifery Supervisors	None- This is already recommended best practice	Jan 2014	<p>Message shared through midwifery child protection link meeting (Nov 2013). There is a section in the yellow hand held notes to allow recording of fathers details.</p> <p>Audit Completed Dec 2013 positive results. To remain on annual midwifery audit plan</p>
To contribute to the current evidence base by ascertaining if there are any 'red flags' for eye injury presentations in babies	To complete an activity analysis and evaluation of under 6 month babies attending CED /BEH as emergencies, including a review of Child C's presentation	Named Doctor/Nurse supported by key professionals at the BEH	Protected time for the Named / BEH Professionals to complete project work.	June 2015	<p>Meeting held with key professionals from CED/BEH. Analysis completed.</p> <p>Action plan developed. Joint work completed in CED /BEH to review Safeguarding process for babies, based in Infant Assessment Tool. Babies are now undressed and weighed as part of the routine assessment, based on guidance within the National</p>

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
					Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP)
To promote best safeguarding practice in management of injuries under ones presenting with minor injuries	Implementation of 'Infant Safeguarding Tool' across all Bristol urgent care/emergency departments and minor injury units	CCG HIT team and designated professionals/ Named Professionals	Protected time for the Named / Professionals to complete project work	March 2014	<p>Infant Tool validated through second audit. Named Nurse has presented to CED/ GP consortiums/ CPHAG/MIU.</p> <p>April 2014 Infant tool presented at Health Professionals meeting to develop Protocol for infants presenting with injuries. May be adopted as part of the SWCPP</p>
To clarify the use of CHIN 1 & 2 forms to promote effective information sharing both between health professionals and with Children's Social Care	To review the use of the CHIN 1& 2	Named Midwife/Midwifery Safeguarding Supervisor (NBT)	This project will be undertaken by the Midwifery Safeguarding Supervisor due in post Dec 2013	June 2014	NBT have implemented the 'Request for Help' form for safeguarding referrals, following the remodelling of Bristol Social Care and First Point referral form for S Glos.

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
To produce an 'options paper' considering information sharing between Children's Outpatients and the HV/SHN. This may also include inpatient discharge information	Formation of a short life working group to explore information options within the constraints of the current information systems	HV Manager NBT/Named Professionals/UHB	Protected time for the Named / Professionals to complete project work	End March 2014	<p>First meeting held Nov 2013.</p> <p>Progress update: May 2014 Work ongoing with IT/ Safeguarding leads to work towards the long term objective i.e. the electronic transfer of information to SHN/HV.</p>

3. Primary Care

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
To improve the reviewing and management of notifications received by GP's in relation to children attending emergency settings with injuries	Share the system already in use at one GP Practice in South Gloucestershire with other practices through the Lead GP Meeting	Designated Nurse/Named GP	None	January 2014	GPs reminded at Lead GP meeting in November 2013 of the importance of having an awareness of safeguarding aspects when reviewing notifications. Audit undertaken of GP practice standards in Jan 2013/May 2014 demonstrates compliance. Self-assessment audit of individual GP competences undertaken in May 2014. Results will be shared during the training planned for 2014 which will also include all of the learning points from the SCR.

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
To enhance primary care professionals assessment of injuries in infants under one year and/or injuries with unusual mechanisms	Implement the use of the 'Assessment Tool for injuries in infants under 12 months' authored by the Named Nurse from UHB, to be circulated to all practices	Designated Nurse/Named GP	None	As soon as available	GPs reminded of importance of having an awareness of safeguarding aspects of injuries in infants under 12 months at Lead GP meeting in November 2013. Self-assessment audit of GPs competencies undertaken in May 2014 includes recognising potential indicators of child maltreatment – physical abuse and understanding the assessment of risk and harm. Results will be shared during the training planned for 2014 which will also include all of the learning points from the SCR.

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
To review the guidance for GP's about requesting case consultations to increase and enhance supervision in relation to injuries in infants under one year and/or injuries with unusual mechanisms	Share reflective learning from this SCR with all South Gloucestershire GP Practices	Designated and Named Professionals through Lead GP meeting and re launching supervision guidance to all practices	None	January 2014	GPs have been reminded through Lead GP meetings, CCG GP newsletter and re circulating safeguarding children guidance to all practices. Training planned for 2014 will include all the learning points from the SCR.
In partnership with providers of health visiting services, to formalise the structure of Health Visitor and GP liaison meetings to ensure that for all children/families where there is cause for concern there is robust sharing of information	Ensure sharing of good practice/meeting structure established in another South Gloucestershire GP Practices with all practices	Designated and Named Professionals	None	January 2014	Audit undertaken of GP practice standards Jan 2013/May 2014 demonstrates compliance with the standard Discussed with Named Nurse responsible for Health Visiting.
In partnership with providers of maternity services review the process and proforma for antenatal risk assessments and the sharing of information between primary care, midwives and health visitors	Review the process	Designated and Named Professionals	None	March 2014	Discussed with Named Midwives responsible for maternity services within the two main providers. To be discussed fully as an agenda item at CPHAG meeting in July 2014.

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
<p>Practices to be encouraged to consider implementing a system of identifying and allocating families of young children who are frequent users of the service, to a specific GP who should co-ordinate their care with flagging of their records to indicate which GP they should be directed to</p>	<p>To present to a Clinical Commissioning Membership meeting and a Protected Learning Time event for all South Gloucestershire Practices</p>	<p>Designated and Named Professionals</p>	<p>None</p>	<p>March 2014</p>	<p>This is a long term on-going project. The action planned is to encourage GP Practices to adapt the new General Medical Services for England Primary Care Contract requirement of allocating patients over 75 years to a named GP and apply this model to vulnerable families. A schedule of the dissemination of learning from the SCR at CCG meetings has been planned following publication in June until September, this issue will be a major focus of these meetings</p>

4. Bristol Children's Social Care

No recommendations for action or improvement

5. South Gloucestershire Children's Social Care

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
Assessment processes should be reviewed to ensure that men in families are considered even if they do not live in the family home	Review of Assessment processes	Head of Service	None	July 2014	<p>A Practice note has been sent out to all staff informing them of the need to ensure that all men within families are considered within social care assessments, whether they are fathers or significant others. There will routinely be some analysis of their role and function within the family, including analysis of the risks and strengths of their parenting capacity.</p> <p>All agencies have been advised through the LSCB that fathers/significant others should be recorded within CAFs and consideration given to them and</p>

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
					<p>their views within CAF assessments. Father's and significant other's details will routinely be requested and recorded in assessments by all agencies. These details will routinely be shared with First Point by referrers, at point of referral to Integrated Children's services and then subsequently recorded in CSS and ICS by First Point staff.</p> <p>A Practice note has been sent out detailing that fathers with PR should routinely be invited to all meetings regarding children ie TAC, CIN, CPC, core groups etc Significant others and fathers without PR will be invited to meetings regarding children, with the permission of the parent/carer with PR.</p>

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
CSC procedures should be reviewed to require that a re-assessment is undertaken if a new relationship starts or a partner moves into the family home	Review of CSC procedures	Head of Service	None	July 2014	This review and particular issue will be discussed at the next CSC management meeting on 6 th July 14. Procedures will be amended if necessary following this meeting.
The SWCPP should be reviewed to explicitly require a discussion with a Community Paediatrician if any non-mobile baby sustains an injury	Review of SWCPP	Shared Procedures Steering Group	None	September 2014	Awaiting development of procedure
Processes for case closure should be reviewed to ensure that all relevant information is reviewed and signed off and that there is a clear plan in place for on-going support prior to case closure	Review processes for case closure	Head of Service	None	July 2014	A practice note has been sent out detailing that before a child's case is closed to Children's Social Care, the practice manager will complete a reflective supervision record on the child's ICS file which records why the case is closing and will include not only positive factors but also a list of any outstanding risk factors.

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
					Step down procedures are already in place for stepping a case down from social care to CAF. This process will be reviewed and reiterated to staff over the coming month.
Supervision processes should consider the emotional impact of the work being undertaken	<p>A review of supervision processes to ensure they include supporting practitioners on the managing the emotional impacts of their work</p> <p>Supervisors to receive guidance on any recommended changes to process</p>	<p>Head of Service</p> <p>Service Managers/Principal Social Worker</p>	<p>None</p> <p>None</p>	<p>July 2014</p> <p>September 2014</p>	<p>All CSC managers are required to complete the manager's supervision training run by Bridget Rothwell which focuses on provision of reflective supervision within the social care context. The supervision process has been reviewed and already includes supporting staff regarding the emotional impact of their work, however this will be reiterated at the next CSC management meeting on 6th July 14.</p> <p>A review of the supervision policy will take place prior to September 2014</p>

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
Family Support Meetings should take place within the required timescales	An audit of the timeliness of Family Support Meetings	Performance and Quality Sub group	None	July 2014	Due to capacity issues this audit will be delayed until 2015
All CSC practitioners who are case holders should attend update safeguarding training annually. This should be considered as part of PDPR	Requirement to be made explicit to Team Managers	Principal Social Worker	None	March 2014	Awaiting Principal Social Worker. Start date June 2014
	Reporting to SGSCB on training compliance shows improvement	Team Managers	None	July 2014	To be reviewed in July 2014

6. Avon & Somerset Police

No recommendations for action or improvement

7. South Gloucestershire Early Years

Recommendation	Action Required	Lead Officer(s)	Implications for Service Provision	Timescales	Progress
Use of the escalation policy practice	Staff to be trained in the use and appropriateness of the policy	Team Managers	None	January 2014	Revised policy completed, awaiting final sign off prior to staff training (August 2014)
Formal sign off of all closed cases	Evidence of discussion and/or meeting with Line Manager, Partner agency and family to ensure decision agreed and understood	Team Managers	None	March 2014	All cases are discussed in supervision (documented on the "Family Case Review" form), and any actions taken i.e. continue service, referral, case closed, is detailed the "Action Plan area of the form"

8. SURVIVE

No recommendations for action or improvement

Serious Case Review Terms of Reference for Child C

Background

Children's Social Care

South Gloucestershire Children's Social Care were involved with Child C's mother's family in 2009 due to issues in the family of domestic violence and sexual abuse by Child C's Maternal Grandfather of Child C's Mother. The Case was closed in March 2010 and re-opened in Feb 2011 when individual family support was given for both Child C's mother and Child C's mother's brother.

Child C's mother became pregnant by Child C's father with Child's Brother at age 15. Child C's Brother was born on 26 June 2009. Child C's Mother became pregnant again by Child C's father and Child C was born on 17 July 2012. Six weeks after birth the case was closed by Children's Social Care on 17 September 2012.

Child C's mother's new partner had moved into the family home at this time. Child C's mother had started a college course and Child C's mother's boyfriend became the carer for the children whilst she was at college.

Since the death of Child C, checks on Child C's mother's boyfriend have identified that Bristol Social Care have knowledge of his involvement in two previous relationships with women in Bristol that resulted in children. As a result, Bristol Children's Social Care will contribute to the SCR.

Health Services

All the family have received primary health care services. Midwifery services were provided during both pregnancies.

Family was in receipt of an enhanced health visiting service from July 2009.

Child C attended A&E at NHS Trust 2 when Child C's brother was reported to have sprayed hairspray into her eyes. Child C's mother's boyfriend also informed the A&E department of NHS Trust 2 at this time that Child C's brother had been putting clothes pegs on Child C's ears.

Child C also attended the Minor Injuries Unit with both Child C's Mother and Child C's mother's boyfriend. Child C's mother's boyfriend had said that he had dropped Child C on her head and her head had hit a bedside table and when Child C's mother returned home she initiated the visit to the Minor Injuries Unit.

On 6 November 2012 Child C's mother left a message for the Health Visitor concerned about Child C's brother's behaviour particularly that he was being aggressive towards Child C, stating he hits on her face causing bruising.

The Incident 14 November 2012

On the 14 November 2012, Child C was brought to the Children's Hospital by ambulance having earlier been pronounced dead at the family home.

Child C's mother is reported to have left home at 8.45am to attend college, leaving Child C's mother's boyfriend to care for the children. Child C's mother's boyfriend states that he left Child C on the bed and covered her head with a blanket, which they usually did while she slept. He discovered her not breathing at 11.45am and called an ambulance.

On examination, Child C was found to have blisters on her left ear and neck and at the back of her scalp. No medical explanation has been given for these.

The forensic post mortem has not found any natural causes likely to have caused death.

Bruising was also found on Child C's scalp which was likely to have been a few days old. No explanation was given before the death.

Child C's death is given as 'of unascertained causes'.

Serious Case Review Criteria

It is a requirement that South Gloucestershire Safeguarding Children Board (SGSCB) should undertake a serious case review when a child dies and abuse or neglect is known or suspected in the death (Regulation 5 of the Local Safeguarding Children Board's Regulations 2006))

This case was discussed by senior managers at a multi-agency SCR sub group meeting held on 18 June 2013. The group made a decision that the case met the criteria for a SCR. The Chair of SGSCB was advised and decided that, in his view, the criteria for Serious Case Review had been met. The SCR was initiated on the 4 July 2013.

Scope of this Serious Case Review

The SCR Panel expect, as a minimum, IOR authors to provide a detailed chronology that identifies critical points/key practice episodes, between 1 September 2008 until, date of death, 14 November 2012. It would be an expectation that IOR authors will use their professional judgement to locate and comment on other relevant information relating to this case, including information that has come to light since the death of Child C. This will include consideration of relevant aspects of family history, rapid response and post mortem findings.

Consideration should be given to any relevant previous convictions, intelligence, matters of medical history, education and social functioning of the children's parents/carers relevant in contextualising the life of Child C.

Serious Case Review Process

This SCR will be carried out in accordance with the guidance contained in 'Chapter 4 Working Together to Safeguard Children 2013'. A SCR Panel will be established drawing upon the expertise of senior managers within agencies who have had no direct managerial responsibility for the case.

This Panel will be chaired by an independent consultant who will also produce the overview report for SGSCB. Individual agencies will be required to complete an IOR for consideration by the SCR Panel.

Timescale for SCR Completion

The SCR will be completed within six month from initiation

Agreeing Improvement Action

SGSCB will oversee the process of agreeing with partners what action they need to take in light of the SCR findings.

Publication of Report

A report will be published and readily accessible on SGSCB's website for a minimum of 12 months. Thereafter the report should be made available on request.

The final SCR report will:

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike; and
- be suitable for publication without needing to be amended or redacted.

SGCCB will consider carefully how best to manage the impact of publication on children, family members and others affected by the case.

SGSCB will comply with the Data Protection Act 1998 in relation to SCRs, including when compiling or publishing the report, and must comply also with any other restrictions on publication of information, such as court orders.

The SCR report will be sent to the national panel of independent experts at least one week before publication. If SGSCB considers that a SCR report should not be published, it will inform the panel which will provide advice.

Purpose of this Serious Case Review

The purpose of this review is to identify improvements which are needed and to consolidate good practice.

This SCR will be conducted in a way that:

- 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.

The SCR will adopt a systems approach to the learning from the case. It will seek to look for causal explanations and explain not simply what happened but why it happened and how the systems and organisational cultures influenced the decisions and actions taken by individuals at the time (Fish, Munro and Bairstow, 2009)

The cornerstone of the approach is that individuals are not totally free to choose between good and problematic practice. The standard of their performance is influenced by the nature of:

- the tasks they perform;
- the available tools designed to support them;
- the environment in which they operate.

The approach, therefore, looks at why particular routines of thought and action take root in multi-agency professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice. Ideas can then be generated about ways of re-designing the system at all levels to make it safer. The aim is to 'make it harder for people to do something wrong and easier for them to do it right' (Institute of Medicine, 1999, p. 2, cited in Fish *et al.*, 2009, p.2).

Serious Case Review Panel

The purpose of the SCR Panel is to bring together and collate and analyse the information contained in the IORs together with any reports commissioned from any other relevant bodies or interests. From these, the SCR Panel will commission the independent author to write the overview report and the executive summary in accordance with the agreed timescales.

The Panel will agree the Terms of Reference, review the progress of the enquiries, consider drafts of the IORs and give consideration to the conclusions and recommendations prior to submission to the full SGSCB.

The Panel works within the statutory requirement for the notification of concerns and will do so should any arise during the process of this review. The Panel will also consider the handling of any potential media issues.

Members of the panel are:

Agency/Authority	Position
Andrew Haley	Panel Chair and Independent Lead Reviewer and Overview Report Author
Avon and Somerset Police	Detective Chief Inspector
Avon and Wiltshire Mental Health Partnership	Managing Director, AWP South Gloucestershire

Agency/Authority	Position
NHS Acute Sector	Designated Director,
South Gloucestershire Council	Head of Commissioning, Partnerships and Performance
South Gloucestershire Council	Solicitor
South Gloucestershire residents	Lay Member
South Gloucestershire Clinical Commissioning Group	Designated Nurse for Safeguarding Children
South Gloucestershire Clinical Commissioning Group	Designated Doctor for Safeguarding Children
South Gloucestershire Council	Head of Education, Learning and Skills
South Gloucestershire Council	Head of Integrated Children's Services,
Bristol City Council	Service Manager

Aims of Individual Organisation Review Reports

Individual organisation review authors must be aware of the timescales for completing the chronology and the IOR report, and raise any difficulties in meeting timescales as early as possible with their agency's Designated Senior Manager. The Individual organisation review authors should begin quickly to draw up a chronology of their agency's involvement with the child and their family. IOR authors need to be aware how their work fits into the whole programme, e.g. the timescales for creating the merged chronology being dependent on each agency's chronology being available.

The chronology must be completed on the proforma provided and be a record of the information known and recorded at the time. Where an agency became aware of information relating to earlier events at a later date this should be recorded at that later date. The chronology is not designed to be an accurate chronology of the family history, but of the agency knowledge and action. (e.g. where a family moved house in April but the Health Visitor found out in June the chronology should record the date the Health Visitor was informed, not the date the family moved).

The analysis element of the IORs, whereby the **key practice episodes** in the chronology is reviewed to identify how the systems and organisational cultures influenced the decisions and actions taken at the time in terms of both good and poor quality of practice is particularly important.

Conducting the Individual Organisational Review

Authors have a responsibility to consider the statutory requirement for the notification of concerns.

The emphasis of the review under systems methodology is to gain insights into how the multi-agency child protection system is functioning within South Gloucestershire. It is therefore important to study the whole system and gain insight into why particular thoughts and actions take place. When you interview each of the key professionals from your agency who worked with this family during the period under review, it would be helpful to seek answers around the following questions:

Practitioners' Narrative

What do you think were the crucial moments in the sequence of events when decisions or actions were taken that you think determined the direction the case took, or the way it was handled?

What were your main concerns? What were you considering and seeking to balance at the time? Did these concerns clash at all? Were there any conflicts? Were some dismissed, others prioritised? What were you hoping to achieve? What options did you think you had to influence the course of events? What was behind your thinking (reasons but also emotions) and actions at the time? What information was at the front of your mind? What was most significant to you at this point? What was catching your attention?

What were the key factors that influenced how you interpreted the situation and how you acted at the time? In what ways? Prioritise aspects that were most significant?

Aspects of the family

Aspects of your role

Conditions of work/work environment

Personal aspects

Your own team factors

Inter-agency/inter-professional team factors

Organisational culture and management

Wider political context

Other

What things in relation to the case went well? What did you and/or others do that was useful/helpful? What enabled this to happen?

Suggested changes, having thought back on this case and your role, are there any small, practical changes that you can think of that would help you or other professionals to achieve better outcomes?

How do you feel now about your role, particularly, what support would you have benefited from at the time of the difficult decisions you had to make and what support would you benefit from now?

Agencies Who Contributed Individual Organisational Reports

Agency Report
South Gloucestershire Council
Bristol City Council
NHS Trust 1
Avon & Somerset Police
General Practitioner (GP)
Early Years Service
NHS Trust 2
Survive

GLOSSARY

SIGNIFICANT FAMILY MEMBERS	
Child C	SUBJECT (CHILD)
CB	CHILD'S BROTHER
CM	CHILD'S MOTHER
CF	CHILD'S FATHER
MBF	MOTHER'S BOYFRIEND
MGM	MATERNAL GRANDMOTHER
MGF	MATERNAL GRANDFATHER
MGFX	MATERNAL GRANDFATHER'S EX PARTNER
MBC1	MOTHER'S BOYFRIENDS CHILD 1
MBC2	MOTHER'S BOYFRIENDS CHILD 2
MBFX1	MOTHER'S BOYFRIEND'S FIRST EX PARTNER
MBFX2	MOTHER'S BOYFRIEND'S SECOND EX PARTNER
MB	MOTHER'S BROTHER
OTHER	
SGSCB	SOUTH GLOUCESTERSHIRE SAFEGUARDING CHILDREN BOARD
SCR	SERIOUS CASE REVIEW
IOR	INDIVIDUAL ORGANISATION REVIEW
CSC	CHILDREN'S SOCIAL CARE
HV	HEALTH VISITOR
GP	GENERAL PRACTITIONER

Overview Author Brief Biographical Note

Andrew Haley trained as a teacher and a social worker. He has worked in social care for 33 years, initially as a local authority social worker and later in a range of management roles. In recent years his experience has been employed in senior interim roles, focussing on service improvement.