BUCKINGHAMSHIRE SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

Baby E

Edina Carmi

13.03.13

Contents

1 INTRODUCTION

1.1 BACKGROUND

1.1.1 In Spring 2012 a 14 week old baby (referred to as baby E) was presented at hospital with a history of poor feeding and being unsettled. The baby was diagnosed at hospital as having suffered a fractured femur.

1.1.2 Three weeks earlier the baby had been seen at the hospital with facial bruising which a consultant paediatrician had concluded was 'less likely to be accidental injury'. Since that time there had been a child protection enquiry and criminal investigation into the bruising, but this had not yet been concluded. The baby had been living at home throughout this period as it had been considered that the baby's mother would be able to protect her children from further harm.

1.2 PUBLICATION

1.2.1 In line with publication requirements for serious case reviews, this report has been anonymised. To protect the identity of the children concerned their gender and birth dates are not included in the report and the precise dates and location of events have not been provided. The children are referred to as 'baby E' and 'child F.

1.3 REPORT CONSTRUCTION

1.3.1 The report is laid out as follows:

- Introduction (this chapter)
- Review process
- Family background
- Narrative of agency involvement during the period under review
- Opportunities for intervention
- An analysis of the practice and lessons learnt
- Conclusions with respect to general and agency-specific practice and lessons to be learned
- Recommendations
- A glossary of abbreviations used within this report

2 REVIEW PROCESS

2.1 INTRODUCTION

2.1.1 Donald McPhail, the independent chair of Buckinghamshire Safeguarding Children Board decided on 15.05.12 that the circumstances met the criteria for a serious case review because of the severity of the injuries and the initial evidence that agencies did not work effectively together, in particular in making the assumption that mother could protect children without adequate checks and assessments.

2.1.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards to undertake reviews of serious cases in accordance with procedures set out in chapter 8 of Working Together to Safeguard Children HM Government 2010.

2.1.3 A Serious Case Review should be initiated when a child has died and abuse or neglect is known or suspected to be a factor in that death. Its purpose is to:

- 'Establish what lessons can be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result and
- As a consequence, improve intra and inter-agency working and better safeguard and promote the welfare of children'

2.2 SERIOUS CASE REVIEW PANEL MEMBERSHIP

2.2.1 Members of the panel set up to consider the case were as follows:

- Donald McPhail (Independent Chair)
- Business Manager BSCB
- Head of Children's Quality Standards and performance – BCC
- Detective Inspector – Protecting Vulnerable People Manager – TVP
- Senior Psychologist – BCC
- Development Officer – Buckinghamshire Safeguarding Vulnerable Adults Board
- Operational Lead for Children and Young Peoples Community Services (BHT)
- Designated Doctor for Child Protection (NHS Bucks)

2.3 INVOLVEMENT OF LOCAL AGENCIES

2.3.1 The following local agencies were identified as having potential information of relevance to the serious case review and were asked to provide an individual management review:

- Local Authority Children and Families (C&F): provides the children's social care service
- Local Authority Adults and Family Wellbeing: manages the Out of Hours Service for both children and adults social care
- Thames Valley Police (TVP)
- Buckinghamshire Healthcare NHS: health visiting service, maternity services and Stoke Mandeville Hospital
- General Practitioners (GPs)

2.3.2 Additionally information was obtained from the nursery attended by child F, baby E's sibling.

2.4 TERMS OF REFERENCE

2.4.1 The SCR panel determined that learning could be maximised by asking each agency to review the period from 01.07.11 to 16.04.12 and establish:

- What assessments, including those relating to domestic abuse, were undertaken and the quality of those assessments
- What risk factors were identified in relation to the children
- If plans were implemented and to what extent the plans addressed any risk factors identified in the assessments
- If agencies shared information appropriately and involved other professionals or agencies as necessary
- If assessments took full account of the information available to the agency
- To what extend the "voice of the child" and "voice of the sibling" were heard in terms of understanding the needs of the child and taking account of their experience in the family
- To establish if there were factors which enhanced or impeded working relationships with the parents
- To what extent the parenting capacity was considered and addressed
- To what extent the father and male carer/ partner were identified and assessed in relation to their roles with the children
- If the diversity needs within the family were identified and addressed
- If there were any capacity issues within agencies that impacted on the quality of the services provided
- If staff involved had the skills, knowledge and experience to address the issues within the family
- If staff within agencies co-operated to achieve the best outcomes for the children
- To what extent strategy discussions/meetings provided a clear framework for the investigation of concerns
- To what extent individual agency and multi-agency policies were adhered to and to comment on the adequacy of those policies
- If staff directly involved had appropriate supervision and managerial guidance

2.4.2 During the course of the review it was identified that information was required about the partner's history in his previous relationship in so far as it is relevant to care of children E and F. Excluded from the scope of this review is any analysis of the agencies responses in terms of the care of the children in this second household.

2.5 INDEPENDENCE

2.5.1 Panel members had no prior involvement with baby E or the family; the panel was chaired by Donald McPhail, the independent chair of the Local Safeguarding Children Board, and the overview report was written by a suitably experienced author Edina Carmi, who has no connection with the agencies or professionals involved in this case.

2.5.2 Each agency's own individual management review was drafted by a suitably qualified individual with no line management or supervisory responsibility for the case. An independent health overview report was also provided.

2.6 INVOLVEMENT OF FAMILY

2.6.1 It was planned to involve family members in the review process, but to date this has not proved possible, due to the criminal investigation. When the police are able to agree this, interviews will be offered to mother, father and maternal grandparents and an addendum provided of their contributions.

2.7 INVOLVEMENT OF STAFF

2.7.1 The individual management reviews of each agency describe the extent to which staff have been involved through interviews. As part of the quality assurance process the panel agreed the need for any additional information from staff.

2.8 QUALITY ASSURANCE PROCESS OF IMRS

2.8.1 The serious case review panel met with the authors of the individual management reviews on several occasions to provide challenge and quality assurance, with the result that all the reports provided covered the required scope comprehensively and effectively analysed the practice within the agency, including consideration of systemic factors.

2.9 RECOMMENDATIONS & ACTION PLANS

2.9.1 Recommendations arising from the multi-agency perspective are provided at the end of this report, along with the individual management review recommendations for improving service delivery.

2.9.2 Each agency has produced its own action plans for implementation of IMR recommendations, stating how each recommendation has been or will be implemented, identifying the responsible person, the progress made and the timescale for its achievement. These have been incorporated into an integrated action plan including the recommendations arising from the multi-agency analysis in the overview process.

3 FAMILY BACKGROUND

3.1 INTRODUCTION

3.1.1 This section provides information about the family structure and what was known by agencies prior to the period under review, before July 2011. So as to preserve anonymity, the children's genders are not identified, no names are used, with family members described by their relationship to children E and F. Mother's partner has been called Mr P.

3.2 FAMILY COMPOSITION

Table 1: Members of household during period under review

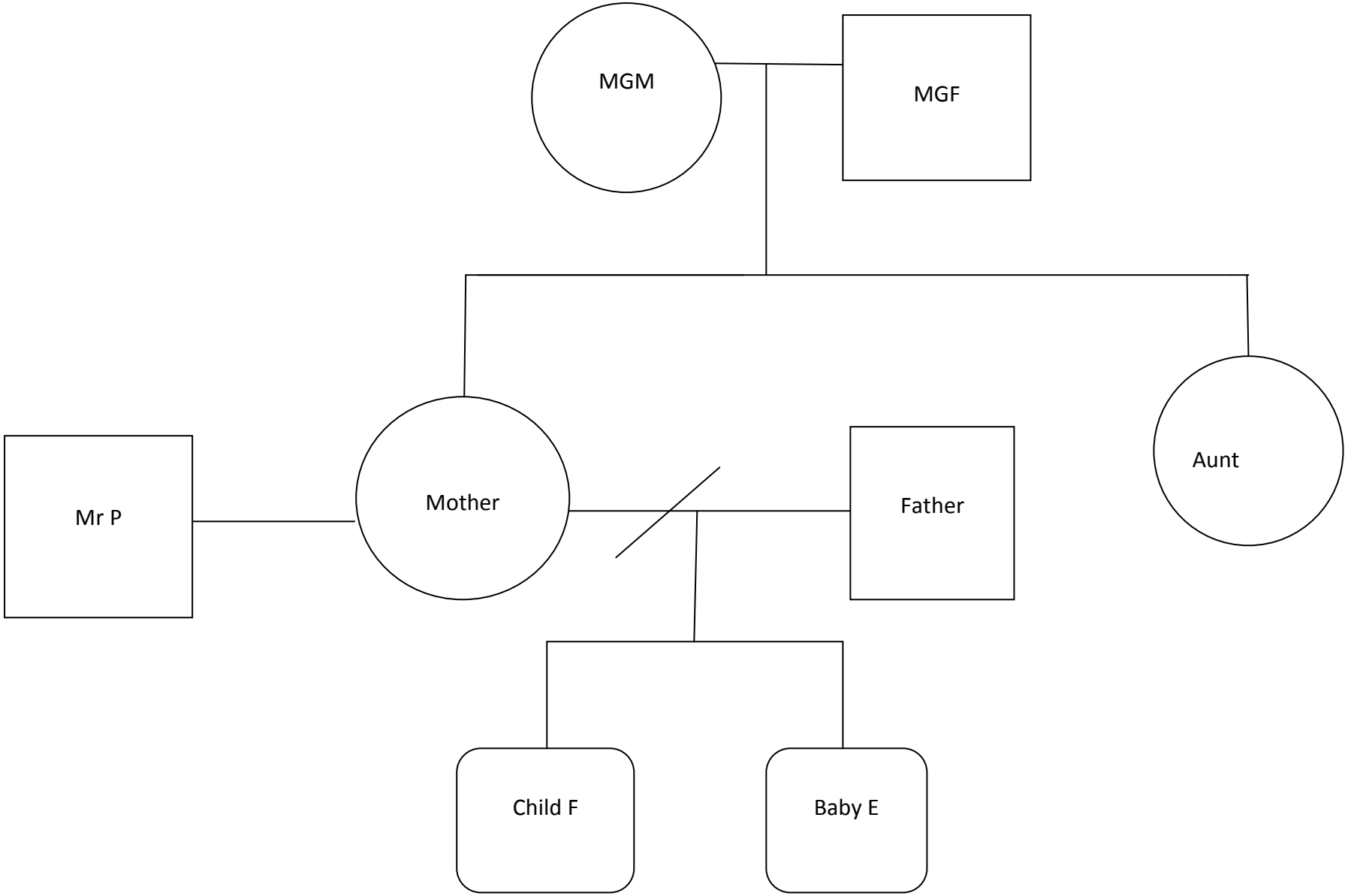
Term / name used	Relationship	Address
Baby E	Subject of the review	Address 1
Child F	sibling	Address 1
Mother	Children's Mother	Address 1
Mr P	Mother's partner	Mr P joined Address 1 around New Year 2012 – previously stayed with ex-partner (see below)and also with family in London

3.2.1 Mr. P had an on / off relationship with Ms Q until the end of 2011. When the relationship was 'on' he lived with her and her children. Mr P was the father of the youngest child, born in 2010. He also has another child from an earlier relationship but no relevant information about her/him was available to the review.

Table 2: Other significant people

Term Used	Relationship	Address
Father	Father of both children	Address 2
MGM	Maternal grandmother	Address 3
MGF	Maternal grandfather	Address 3
Aunt	Aunt to children: Mother's sister	Unknown

3.3 GENOGRAM



3.4 CONTEXT: WHAT WAS KNOWN OF FAMILY PRIOR TO REVIEW?

Relevant agency history of parents

3.4.1 Prior to Mother's pregnancy with Baby E, agencies had little contact with the family. Mother was referred to Children & Families Service (C&F) by her school at age 15 when she complained of a sister hitting her and her own mother being verbally aggressive. She stayed with her grandmother for a few months before returning home after reconciliation.

3.4.2 There is no relevant information about Father prior to the relationship with Mother.

Parental relationship

3.4.3 It is not known when children E and F's parents started a relationship but child F was born when Mother was aged 18 and Father was 23 years old. There are no details of the antenatal care; the health visitor's management review indicates that there were no concerns raised in the pregnancy. At the time Mother and baby were living with Mother's parents (MGM and MGF) and Mother's sister. The child's Father stayed overnight for part of the week.

3.4.4 When child F was aged 2 months old the health visitor noted that Mother was not eating well, was low in mood and experiencing difficulty coping with the demands of a baby. The health visitor organised a 3rd post natal appointment as this remained outstanding and Mother was told that social care would be informed if she did not keep this appointment.

3.4.5 When the health visitor returned two weeks later, Mother was brighter, working part time as a cleaner with her sister at a local school and MGM was helping with childcare.

3.4.6 The health visitor had further involvement when child F was aged 5 months and Mother and baby attended 2 baby massage sessions, when positive interaction was noted. She introduced Mother to the facilitator for Baby Steps at the Children's Centre and supported an application for supported housing, where Mother and baby moved 2 months later and the health visitor became involved again due to concerns about Mother's hygiene and management of child F.

3.4.7 At that point, Mother recounted to the health visitor that child F's Father had lost his job and was staying in her own family's home. He was not happy at her living away, so she visited her family daily. In fact, according to the health visitor's individual management review she rarely slept at the supported housing and her baby never stayed, remaining with the Father at the home of MGM and MGF. Soon after the Mother returned to her family's home and declined further health visiting support. She did not attend Baby Steps and missed a routine family health assessment due when child F was 11 months old in summer 2009.

3.4.8 In 2009 the parents' relationship deteriorated and they split up, with Mother reporting to police she was being harassed by her ex- partner. She alleged receiving 40 calls, sometimes 'threatening' with regard to her neglecting their child. Mother gave a statement, other agencies were informed and Father was arrested and given a Harassment Warning.

3.4.9 A week later Mother alleged to police that Father had started to hug and kiss her. He was arrested on suspicion of common assault with no further action taken, due to lack of evidence.

3.4.10 It is not known when the couple resumed and ended their relationship again, but Father is baby E's biological Father.

Relevant history of Mother's current partner

3.4.11 It is understood that Mr P himself from a very early age suffered abuse in his childhood and was at times subject to a child protection plan.

3.4.12 He has 2 children, one from an earlier partner and one from a relationship with Ms Q. It is not clear when that relationship started as:

- The police chronology refers to a domestic violence incident between Mr P and Ms Q in September 2008
- The C&F individual management review mentions the social worker for Ms Q's four children being introduced to Mr P in September 2009 when he was described as Ms Q's new partner – at this point all the children had been subject to child protection plans since October 2008 due to concerns about neglect and maternal mental health problems

3.4.13 The view in 2009 of C&F was that Mr P was supportive to his partner and had a good relationship with the children.

3.4.14 In 2010 Mr P had a 'drug overdose' in London which the GP individual management review links with a separation from his girlfriend who was pregnant. His GP records do not include information about his partner's children, his parenting ability or any child protection issues.

3.4.15 At a 2010 child protection conference the couple were described as arguing a lot. This conference also functioned as a pre-birth conference on the couple's unborn baby. As part of the child protection plan, Mr P was requested to attend a Parenting Assessment.

3.4.16 Within days of the conference, the childminder took one of Ms Q's children to A&E with bruising to the head, face, knees and elbows. The bruising was judged to be inconsistent with Mr P and Ms Q's explanation (falling out of the bed). Moreover, one of the siblings, said 'daddy' to the childminder (when asked about the injury) whilst doing a hitting over the head action. Ms Q said she was aware of the injury when Mr P was looking after the children and of another injury 2 weeks previously from a trampoline. The 4 children were made subject to Police Powers of Protection (PPoP) and all the children stayed with the childminder for 3 weeks whilst an investigation was undertaken. The police decided not to charge Mr P 'as the injuries were adequately explained' (according to the police chronology for this review).

3.4.17 Following the birth of their baby in 2010, home circumstances were considered to have improved to such an extent that child protection plans were removed at the next child protection conference. Mr P was described as a 'hands on father' and the couple's baby considered to be thriving, with the care of the other children improved since Mr P joined the household. There had been no further injuries and it was concluded that the occasion when the child was injured was a result of Mr P's inadequate supervision as opposed to non accidental injury. The case was subsequently closed to C&F.

4 NARRATIVE OF PROFESSIONAL INVOLVEMENT

4.1 INTRODUCTION

4.1.1 This chapter provides an account of agencies' contact and intervention with the family in the period under review, 01.07.11 to 16.04.12. Because Mother's current partner joined the family during the period under review, also included is the narrative of agencies involvement with his previous partner's children (The Q family).

4.1.2 So as to render more accessible a large volume of material, this section has been divided into the following periods:

- Prior to relationship between Mother and Mr P
- Birth of Child E
- Baby E in neo natal unit (NNU)
- Baby E at home: aged 9 – 11 weeks
- Initiation of Child Protection Enquiry
- Joint investigation
- Further injuries to baby E

4.1.3 Each of the practice periods is prefaced by a short list of 'key dates' (events or professional decisions) extracted from the multi agency integrated chronology that accompanies this overview report.

4.2 PRIOR TO RELATIONSHIP BETWEEN MOTHER AND MR P

4.2.1 This section covers the Mother's pregnancy with baby E and narrative of the agencies involvement with Ms Q's children in the period prior to the start of the relationship between Mother and Mr P.

Date	Event
Early July 2011	**Domestic Violence incident 1:** Police Domestic Abuse report concerning Mr P and Ms Q includes alleged punch in face, theft of money and verbal argument: Ms Q subsequently retracted assault
Late August 2011	**Domestic Violence incident 2:** Ms Q reported that she had been receiving threatening texts from Mr P since end of relationship
	Mother's pregnancy confirmed
Early September	**Domestic Violence incident 3:** Ms Q reported brick thrown in garden
Late October 2011	**Domestic Violence incident 4:** Mr P alleged to have seriously assaulted Ms Q in presence of at least one of children

November 2011	5 children made subject to protection plan due to risk of violence in household between the adults and that Mr P may have been violent to the children
End December 2011	Ms P informs C&F that the relationship between her and Mr P was over (again)

** Precise dates not provided to preserve anonymity*

Mother's second pregnancy

4.2.2 There was nothing of note during this period other than routine ante natal care.

4.2.3 Child F's Mother's had her pregnancy confirmed in August 2011 and in September was booked at home by the same midwife who cared for her in her first pregnancy. Child F was present playing with a friend and there were no concerns identified. Mother had a female friend with her, and whilst identifying the father as child F's dad, she described herself as a 'single parent'. The midwife did not ask any details about Father's involvement with the family nor about domestic abuse and no concerns were raised from this booking in appointment.

4.2.4 The Mother was seen in 2011 at the GP surgery for a routine appointment at 16 weeks gestation and was booked for an appointment 4 weeks later with the GP which she did not attend, but she did attend a scan a few days later at the clinic.

Ending of relationship between Mr P and Ms Q

4.2.5 This period was marked by 4 domestic violence incidents between Mr P and Ms Q, with uncertainty about whether or not the relationship had ended. The information for this period comes from the police and C&F management reviews.

Domestic violence episode 1

4.2.6 In July 2011 Ms Q reported an argument with her partner, Mr P. Initially she stated that she was at home with her 5 children (aged between 7 months and 11 years) and her ex-partner Mr P punched her in the face and stole £30.00. When the police visited an hour later, there was no response and by the next morning when police returned Ms Q explained she had phoned in the heat of the moment and did not confirm an assault had taken place. She was not willing to engage with Officers to complete a DASH Risk Assessment Form and family members stated it was a verbal argument. The Officer decided no offence had taken place and the incident was graded as 'Domestic Incident – Non Crime' with a 'Standard' [1]Risk Assessment level. Other agencies were informed of the incident, including the alleged assault.

Domestic violence episode 2

4.2.7 At the end of August 2011 Ms Q's friend called the police reporting that the couple had split up, but he was hounding her with calls and texts: 90 texts in 2 days. Some involved threats e.g.: *'I'm gonna do the house over whether the kids are in it or not, either smash it up or blow it*'. Ms Q stated she already had holes in her walls and doors from previous incidents and she believed his threats as he had been violent in the past. He was thought to

[1] Standard Risk Assessment level (DASH) 'Current evidence does not indicate likelihood of causing serious harm'

be staying with his sister in London, but Ms Q's friend called to report seeing Mr P driving a car with 2 children in it.

4.2.8 The police took a statement detailing full history of the relationship. Ms Q completed the DASH form and this was graded as medium risk[2] . A repeat DV (domestic violence) flag was placed on the address, with classification of 'Nuisance Messages – Non Crime CRI.'

Domestic violence episode 3

4.2.9 2 days later at 23.13 hours, Ms Q called police again reporting that someone had tried to throw a brick through her window and that she had 5 children in the house. Police initiated an area search and (following a repeat call from Ms Q) attended the scene at 01.10 hours. Ms Q explained she had been in this relationship on and off for 2 years, that Mr P would become aggressive without regular cannabis use, had begun to control her movements and reduce contact with her friends, he damaged property and punched her. However, Ms Q withdrew support from the investigation due to her fear of more trouble from Mr P. Ms Q also explained that Mr P had in fact punched her causing facial injury in the July incident.

4.2.10 Ms Q explained that Mr P's behaviour was 'scaring the life out of her', that he and his brother were near the home 2 days previously, that she had spoken to him that evening for the first time since they split up, he later sent a text saying he wanted nothing to do with her and was in a new relationship but around 23.00 she heard a loud 'bang' and found the back gate open and a half brick in the garden. Ms Q completed the risk assessment form (with the same police officer as previously), and mentioned receiving 97 texts in 1 day. Again this was graded as 'medium risk'. The police officer created a record of the incident 'Domestic – Non Crime'.

4.2.11 Around 9.00 hours Ms Q called again as Mr P had turned up with his brother in law in a blue car. She had left her house and was en route to a friend's. Police attended, but as no further threats were made recorded that no offences disclosed and no new / updated DASH form was completed. Other agencies were informed of the incident.

4.2.12 Police followed the incident up and spoke to Ms Q by telephone a few days later. She explained there had been no further problems and she was happy with his contact for the purposes of seeing the children. She was given advice, such as calling 999 in an emergency and the 'SigFlag' remained on her address.

Domestic violence episode 4

4.2.13 In late October a neighbour of Ms Q called the police at 20.53 in the evening. Ms Q was at her door asking her to call police as Mr P had hit her and damaged the kitchen. He was with the 5 children in her home – the children were awake. Ms Q said he had been violent to her previously, but not to the children, although was shouting at the 7 year old as she fled the house. He had been drinking.

4.2.14 A few minutes later Mr P called police himself to say he had been attacked by his partner (alleged to throw a fridge) and that he had marks on him. He said he was concerned for the children who were alone, and offered to meet police at the end of the road.

[2] Medium Risk Assessment level (DASH) 'There are identifiable indicators of risk of serious harm. The offender has potential to cause serious harm but is unlikely to do so unless there is a change of circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse'

4.2.15 A police officer attended immediately and found Ms Q distressed at the neighbour's home. She explained they had been drinking when her sister visited, then afterwards he hit her and pushed the fridge. After a reminder from the control room that the children were unsupervised, police officers undertook an area search. 25 minutes from the initial telephone call, Ms Q returned to her home with a police officer and found the children unharmed.

4.2.16 Mr P was located shortly after this and arrested on suspicion of assault, and subsequently also theft, criminal damage and possession of cannabis.

4.2.17 Ms Q's written statement explains that Mr P started yelling asking if she was seeing someone else and stated that such jealousy is common. She described Mr P punching her twice and grabbing her hair, her biting him to try to get him to release her, Mr P trying to slam her head on the kitchen counter and her falling to the floor, Mr P allegedly repeatedly punched and kicked her (20 times in total), with her eldest son screaming for him to 'get off'. As Mr P stood up to go upstairs, Ms Q escaped from the home, having sustained bruising to head, and with her arms and legs hurting.

4.2.18 Before Mr P left the house he was alleged to push the fridge over, ripped the grill off the back and pulled the TV in the bedroom off the wall, showering the room with glass and smashing the drawers. He ripped up a framed poem in relation to her daughter who died in 2XXX, smashed Ms Q's phone, removed the SIM card and stole her bank card.

4.2.19 The revised DASH form describes Ms Q as 'terrified of what he will do when he finds her' and was graded as 'high'[3] risk.

4.2.20 However the next day when reviewed, the Risk Assessor changed the grading to medium because both adults known for some time, that the incident suggests she had not ended the relationship as previously reported, that he did not follow her when she left but called the police. The officer commented that Mr P had the opportunity to commit serious harm in the incidents but did not do so (so not imminent harm) and although Ms Q says she is frightened she declines to stay at a safe address. As Mr P was not on the tenancy the officer suggests Ms Q could exclude him from the address to reduce the risk and she 'states he is always groping her and he can't just cuddle her'.

4.2.21 A notification was sent to other agencies and a social worker discussed what had occurred with a police officer, who then completed a victim safety plan.

4.2.22 Mr P was interviewed by police and provided an alternative account of events, whereby Ms Q attacked him and threw the fridge at him, he hurt his arm trying to catch it, she may have unintentionally hit her head on the kitchen surface when her leg gave way and he left the house thinking Ms Q was in the living room. Mr P was bailed to allow for further enquiries (photos of the injuries, download of 999 call, statement from neighbour, an account from 7 year old child and house to house enquiries). Bail conditions prohibited contact with Ms Q.

[3] High Risk Assessment level (DASH): 'There are identifiable indicators of risk of serious harm. The potential event could happen at any time and the impact would be serious. Risk of serious harm means a 'risk which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, can be expected to be difficult or impossible'

9 days later

4.2.23 9 days from the date of the incident, the police officer involved on the night in question took a statement from Ms Q. By that point she said the children were missing Mr P and although having mixed feelings thought it best for him to be back in the house. She no longer supported a police investigation.

Case review in police

4.2.24 A case director (P18) the next day requested all the evidence be submitted to consider a prosecution without the victim's support, stating he had serious concerns for the safety of the victim and family.

Child protection conference

4.2.25 The C&F individual management review refers to the children making allegations about Mr P once the bail conditions had been made:

- One child said he arm was banged against the wall
- A description was given of a tennis ball being thrown at another child's face
- The children spoke about their unhappiness generally with him in their lives

4.2.26 However, Ms Q would not sign a written agreement prohibiting contact, after which the children are described in the individual management review as ceasing to 'raise issues about ' Mr P.

4.2.27 In mid-November one of the children was injured in the night, and there was some doubt about the Mother's explanation. This was though after Mr P left the home.

4.2.28 An initial child protection conference held at the end of November made all the children subject to child protection plans under the categories of physical and emotional abuse. The defined risks included the pattern of violence in the household and that Mr P may have been physically violent and aggressive to the children. It was recognised that Mr P may still have contact with the children. This was viewed as a risk.

Miscarriage?

4.2.29 In early December Mr P called the police asking for his bail conditions to be lifted as Ms Q was having a miscarriage. Ms Q also called the police to back this up, saying she wanted him with her, mentioning she was about 5 weeks pregnant with his child. The request was declined on basis that the conditions were there to protect Ms Q and her children.

4.2.30 There are no details in police records of what caused the miscarriage and no reference to this in the C&F individual management review.

No further action by police

4.2.31 The police officer involved originally with DV episode 4, in early December 2011 took a statement from the neighbour and re-interviewed Mr P, who repeatedly answered 'no comment'. When subsequently reviewed by another Case Director (P23), a decision of no further action was taken on the 'domestic elements' due to the difficulty of bringing the case without the victim's support, as 'we are reliant on her evidence' and the bail conditions on Mr P were lifted. Subsequently it became clear during December that the relationship between Ms Q and Mr P was continuing and he was staying week-ends.

Ending of relationship between Mr P and Ms Q

4.2.32 On 28.12.11 Ms Q contacted C&F to inform them that the relationship with Mr P was now over. The next day Mr P called his GP due to low mood and thoughts of self harm. He was in London at his relations and was advised to contact local GP there and offered an appointment for the next day. There are no further notes in the GP noted regarding this.

4.3 BIRTH OF CHILD E

4.3.1 This section covers the agencies involvement over several days and especially the day of birth. This day includes the actions and decisions of staff during the night, who responded following a '999' call and illustrates the challenges in such an emergency to obtain an understanding of the family and household composition and make decisions on the basis of limited information availability.

Date	Event
Early 2011	Mother admitted to labour ward with contractions. Steroid injections given to mature baby's lungs.
2 days later	**Domestic Violence incident 5:** Ms Q reported to police over 100 texts and calls from Mr P, which are becoming more threatening
The next day	Mr P given Harassment letter by police
The following day: 02.55 hours	Baby E born unexpectedly at home Mr P called the Ambulance service
03.30	Baby admitted to neonatal unit (NNU) at hospital
03.29	Mother arrived on labour ward
03.30	Request from TVP to OOH to check information on family
05.45	Police inform senior nurse that Mr P only allowed contact with baby when accompanied by Mother
09.52	Social worker from day staff contacts police for update and to express concerns with regard to Mr P
unknown time	Police officer speaks with Mother and learns the relationship with Mr P is very new (4 or 5 days)
unknown time	Police officer raises doubts with social worker about Mother's capacity to care for baby and refers to possible strategy discussion.
12.45	Mother and Mr P visit baby in NNU
13.10	Message from social care that new partner not to be left alone with baby whilst visiting NNU
15.00	Mr P leaves maternity unit
16.15	SW1 and a social work assistant visit Mother on ward in presence of MGM
17.55	Mother and Mr P visit baby E – say she has not been able to contact the Father

Mother's pregnancy

4.3.2 The Mother was admitted to the Labour Ward early afternoon at a date early in 2011 at 27 weeks gestation, with a history of contractions since early morning. She was transferred to the antenatal ward for steroid injections to mature the baby's lungs and treated with antibiotics for a urinary tract infection, before leaving hospital the next day.

5th domestic violence incident reported to police

4.3.3 2 days later the police had received another report from Ms Q of unwelcome texts and calls from Mr P, approximately 100 since she broke up with him on 26.12.11, including threatening ones, such as 'going to give her a good hiding'. Ms Q had deleted the texts and refused to complete a DASH and the risk was graded as 'Standard'. The police officer pP24) updated the crime report detailing 'CRI Harassment Single Incident' and another officer (P25) issued a Harassment Warning Letter[4] to Mr P the following day, advising that any contact arrangements should be made via a solicitor. Notifications were sent to other agencies in accordance with usual procedures.

Birth of baby E

4.3.4 The day after the harassment letter was given to Mr P, he called the ambulance service saying that Mother had given birth to a baby unexpectedly at home and was now holding it in her arms. He had apparently locked himself out of the house and the ambulance crew could not gain entry, so called the police. 2 police officers attended and Mother answered the door. 4 paramedics tended to the baby (baby E), who was identified as only 28 weeks gestation and not breathing.

4.3.5 Baby E was taken to the local Hospital with one police officer, whilst the second officer remained with Mother and her partner, Mr P.

4.3.6 Shortly after that 3 year old child F was found in the home. The Mother's family had arrived and Mother's sister took child F with her. The Mother was taken by ambulance to the hospital to be with her baby.

4.3.7 Meanwhile at 3.30 hours baby E arrived at the Neonatal Unit (NNU) and was placed on a ventilator to support breathing following resuscitation and stabilisation.

Communication between agencies during the night

4.3.8 The Police Control room inspector had meanwhile identified that should the baby die the 'unexplained death' procedures would apply so contact needed to be made with social care for information and a full intelligence check on the address and its occupants.

4.3.9 The Out of Hours (OOH) social care service was contacted at 03.39 and asked to check their databases; they called back at 4.07 with information.

4.3.10 Initially the understanding from the operator in the Control Room was that Mr P was Mother's partner and the 'Dad'. In the subsequent discussion and with further probing from the OOH worker about the strange circumstances of Mr P being locked out, the operator did explain the relationship of Mr P to the family was her/his own assumption.

4.3.11 The OOH worker explained that whilst Mother was not known to C&F, Mr P was known but at a different address, with a different partner, Ms Q and that Ms Q and Mr P have a 16 month old child who was an 'open' case. The OOH worker initially said s/he was unable to provide any further information on the C&F involvement to the police, but advised 'the

[4] TVP IMR explains that' When dealing with a first complaint of Harassment it is common place for Officers and Staff to send the offender a letter explaining that their contact is unwelcome and that it must cease otherwise they may be arrested.'

police to keep the baby in hospital until this morning' [5] and s/he would ask the day team to contact the police and follow up urgently. The OOH record is slightly different and refers to mum and baby to be kept in the hospital.

4.3.12 On subsequent questioning from the operator, the OOH worker expanded on the information s/he had found and gave the (erroneous) explanation that the child was 'not on a child protection plan' but a child in need '… so it may be something to do with their ability to look after the child ...'.

4.3.13 The OOH officer explained that the day staff would be able to access the proper file, but that Mr P was on bail and gave the name of the social worker. The information was emailed by OOH to the Day Team for urgent follow up as agreed with the police operator.

4.3.14 Further research by the police Control Room was undertaken into Mr P and Ms Q, and also by 04.22 hours there was recognition of the identity of the Father of children E and F, with a decision taken by police to leave the Mother to decide when to inform him of the premature birth of his child. It was felt appropriate to leave her to recover in hospital before speaking with her, given the events of the night.

4.3.15 The intelligence checks revealed at 04.35 that there have been previous domestic incidents involving Mr P and Ms Q and that there were child protection issues for her children.

4.3.16 The police advised the hospital at 5.45 that Mother's partner was only allowed contact with the baby when accompanied by Mother, that he had only moved in with Mother 5 days previously, that the older child might have had social care involvement and police were contacting C&F to share their concerns as Mother may need support.

Day staff take over

4.3.17 The NNU liaised with the community midwife team and established that there were no concerns with Mother or her environment prior to delivery.

4.3.18 When the day C&F staff took over, the social worker (SW1) called the police control room at 9.52 hours 'to get more information', all the police officers concerned were on the night shift and unavailable and the matter was being held by the 'radio operator'. The social worker explained that the matter was urgent as 'we've got real concerns about' Mr P and that 'we'd have real concerns if he's in a relationship with this (Mother) and that this child is his...' [6]. The social worker requested an update, full details of what had happened and if any concerns.

4.3.19 SW1 spoke with the social worker for Ms Q's children (SW2) and learnt about the history and concerns. SW2 spoke with Mr P and he explained his account of the night's events.

4.3.20 SW1 contacted the maternity ward at 10.30 and explained that Mother's new partner was known and requested an update. SW1 was informed of the GP surgery where Mother was registered, the identity of the health visitor (HV1), that there was another child with the aunt and that her Father was also the Father of baby E . Baby E was in SCBU and likely to be there for some months.

[5] Quote from transcript of conversation provided as an appendix to TVP IMR

[6] Quote from transcript of conversation provided as an appendix to TVP IMR

4.3.21 SW1 recorded that the midwife described Mr P as being 'quite aggressive' on arrival, asking why the Mother had not been taken to the labour ward. However, the midwifery individual management review author checked with the Matron of the NNU and midwives from both the labour and post natal ward, but none have recalled Mr P being aggressive.

4.3.22 Shortly after this a police CID sergeant contacted the Mother. She said the premature birth was not the result of an assault or domestic violence. The officer noted that 'she does appear to have limited intelligence and I would question her ability to look after a premature baby'. He liaised with CAIU, requested they contacted C&F directly but also contacted the social worker himself having attended the home and judged the living conditions adequate. He removed the 'scene watch' from the home on the basis that he did not believe any criminal offences occurred, and created a Child Protection CRI on the Police Crime Database (Cedar).

4.3.23 The C&F individual management review notes that the police officer told SW1 that Mr P had only recently been in a relationship with Mother, that Mother spoke of being in pain the previous day and saw her GP then woke up in pain during the night before giving birth. The reference to seeing the GP is not backed by the GP records.

4.3.24 The police officer expressed his doubts about Mother's ability to care for the baby, given her limited intelligence and referred to the possibility of a strategy discussion.

4.3.25 The C&F individual management review mentions a hospital midwife initially rejecting such concerns about Mother's capacity, as being the outcome of the stressful birth, but subsequent observations in SCBU led staff to begin to questions Mother's ability to care for the needs of a premature baby.

4.3.26 SW1 visited Mother at hospital with a social work assistant in the presence of MGM. SW1 discussed the existence of concerns about Mr P, which would be explained more fully when SW1 had an opportunity to speak with him.

4.3.27 The Mother explained she got together with Mr P a few days earlier, that he had been staying with her since, albeit not living there and that he worked in London. Mr P had told her of the previous violent relationship, that he was the victim, that there was a harassment order in place, but he felt it should be the other way round. At SW1's expression of concern that the relationship was so new, but Mr P had visited the baby, the Mother responded she had asked him to accompany her and MGM spoke of feeling comfortable with Mr P. The Mother spoke of receiving abusive texts from Ms Q, which supported her perception that Mr P was wrongly perceived as the aggressor.

4.3.28 Mother also explained she had spoken to MGM on the phone when Mr P was getting an ambulance and made the arrangement for her family to come and get child F, so demonstrating to the social worker the supportive nature of the maternal family.

4.3.29 Mother said that the children's father had stated he did not want anything to do with the baby, that he was not reliable and his contact with child F was irregular. Also she alleged that child F had told MGM that child F's father had slapped child F on her face, adding that she did not want contact to take place unless supervised.

4.3.30 SW1 established that child F was going to pre-school and staying with maternal family. She made it clear that C&F would not want child F to be left in the sole care of Mr P. In the evening Mother and Mr P visited baby E and informed the NNU that she had not been able to contact the baby's Father.

4.3.31 The maternity individual management review refers to SW1's stated intention that day to provide the lead midwife for child protection with a written record of the meeting with Mother, but this was never received.

4.4 BABY E IN NEO NATAL UNIT (NNU)

4.4.1 During the 1st 3 weeks of baby E's life it began to be noted that Mother's visits were short and irregular.

Age of baby	Event
1 day	Mother discharged to her home
2 days	SW spoke with health visitor and child F's pre-school
6 days	1st SW home visit (SW1)
7 days	SW speaks with child F's pre-school and health visitor. Learns of concerns around care of child F and allegation by maternal aunt that premature birth caused by fight
8 days	SW requests hospital maintain detailed visiting log
10 days	C&F decide a core assessment required
12 days	Ward round: Mother not been in contact for 48 hours with NNU
13 days	Mother visited NNU and alleged to a paediatrician that the Father had 'hurt' her and child F
19 days	Mother discharged from midwifery care
21 days	Named nurse raises concerns about Mother's parenting
32 days	Allocated to Sw2 for a core assessment
33 days	2nd SW home visit (SW2)
34 days	health visiting team informed of baby E's birth
5 weeks approx	SW2 told of concerns about Mother's lack of interaction with baby by community liaison nurse
6 weeks	Discharge meeting at hospital decided to terminate Father's contact and Mother agrees to increase her visiting
9 weeks 2 days	Baby E discharged to care of Mother (and her partner)

4.4.2 During the first 5 days of baby E's life, hospital records indicate that Mother visited her baby daily for relatively short periods (up to an hour) and brought Mr P with her on one occasion. Father also visited some days, stayed with his baby for a longer time, asked questions and generally took an interest in his child.

Initial assessment

4.4.3 The social worker undertook a home visit when baby E was aged 6 days old. SW met Mother, her partner Mr P and child F. Maternal grandfather (MGF) was also present. The concerns about Mr P were shared with the Mother on this occasion, and Mother agreed she would not leave child F in Mr P's sole care.

4.4.4 The next day (baby E aged 7 days old), the social worker spoke with the pre-school attended by child F and the health visitor and was told that:

- Child F interacts well with peers and adults but recently had low attendance, was not always clean and often smelled of smoke
- A relative reported to pre-school that premature birth was result of fight at the house

- HV last visited home July 2010, that child F's immunisations were up to date and development recorded as normal, but earlier in 2010 there was observation of poor attachment between Mother and child, that Mother struggled with interactive play but did not engage with offers of support for boundary setting and did not turn up when referred to the Children's Centre.

4.4.5 The social worker continued liaising with other agencies the next day (baby E aged 8 days), learning from midwifery that Mother's own midwife was on leave.

4.4.6 The named nurse contacted the social worker to invite her to the ward round and explained that baby E was doing well but remained in the high dependency unit, was being tube fed and at times baby E struggling to breathe. The social worker requested a detailed visiting log to be kept showing when Father and Mother's new partner visit, and explained that the partner's children with a previous partner were subject to a child protection plan and his presence within the family was a source of concern.

4.4.7 On day 16, social worker completed the initial assessment concluding there were concerns about Mother's parenting and Mr P's presence in the household. It recommended the case be transferred to the Assessment & Intervention team for a core assessment. The individual management review helpfully provides details from this including:

- That Mother is a 'vulnerable adult with some learning disability'....could easily be manipulated and controlled by another
- Full information about Mr P's previous history in relation to the Q family
- Child F said to like visiting child F's Father and that he gives child F cuddles, but encouraged by MGF to tell SW1 that Father once slapped child F's face
- MGF noted to have excellent relationship with child F and be the 'main carer'
- Mr P said to have moved into home on 29.12.11
- Mother said there was no incident prior to premature birth, but her sister told school staff that there had been a fight which led to the premature birth
- Child F's school attendance sporadic and presentation sometimes poor
- Child F's attachment to Mother observed by SW1 as possible area of concern and dental needs 'slightly neglected'

Ward round: day 12 of baby E's life: emerging concerns

4.4.8 The SW attended the ward round on day 12 of baby E's life and learnt that there had been no contact from Mother for 48 hours and that she had not replied to attempted communication that afternoon.

4.4.9 The social worker recorded being told about 2 incidents of note in relation to Mr P:

- That Mother's partner was said to have been asked to leave the labour ward shortly after baby E's birth due to aggressive behaviour and
- On one occasion (day 10) the partner was asked to leave the NNU as only parents allowed to visit, and the Father was visiting: both Mother and Mr P ignored this request and both remained on the unit until he left unhappily following the intervention of the senior sister in charge of the unit.

4.4.10 It has not been possible to establish more about the alleged 'aggressive' behaviour as the midwifery individual management review author checked with the Matron of the NNU and midwives from both the labour and post natal ward, but none recalled Mr P being aggressive.

4.4.11 The ward round agreed for a discharge meeting to be held.

Days 13 - 19

4.4.12 The Mother visited the NNU again the next day (day 13) in the morning and evening, following no direct contact with her for nearly 60 hours, despite attempts to reach her on the phone.

4.4.13 She explained that she had not visited due to problems getting child F looked after. She told the paediatrician that there had been domestic violence issues with Father and he had hurt child F and herself. The consultant paediatrician explained the expectations of her as Mother, including calling the NNU if unable to visit and to request updates on the baby's condition. Whilst there were no active concerns around baby E's health, this was a preterm baby, vulnerable in all respects.

4.4.14 The next day there was no recorded contact with Mother. In contrast, Father phoned the NNU asking for an update and to be contacted if there were any changes. He visited 2 days later (day 15), as did Mother and maternal grandparents (for half an hour). Father visited again on day 16 and Mother on days 17 and 18.

4.4.15 Mother was discharged from midwifery care at a home visit on day 19, in the presence of Mr P. The midwife was unaware of social care involvement since the birth of baby E.

Named nurse reports further concerns to social worker

4.4.16 The named nurse for child protection reported to C&F when baby E was aged 21 days that:

- Mother was not forming an appropriate attachment and not meeting her baby's emotional needs
- Mother had been advised by the specialist doctor to visit more often, as at one point there was a 60 hour period between visits. She tended to visit with her parents late afternoon or early evening
- Baby E may have additional needs when discharged, but Mother was not asking questions about what the baby's needs will be and what will be entailed

4.4.17 SW1 agreed to escalate the concerns within C&F for allocation to undertake the core assessment.

Concerns about Mother's parenting continue

4.4.18 Concerns continued with Mother either not visiting or only doing so for short periods in the evening and making 'minimal effort to do anything with baby E. This pattern was communicated by the Community Paediatric Nurse 1 on day 26 to SW1, with the news that baby E might be ready for discharge in 2-3 weeks time.

Children in Q family

4.4.19 During this period the children in the Q family remained subject to child protection plans, which included provision that all contact with Mr P was to be supervised.

Case allocated for core assessment in Assessment & Intervention team

4.4.20 In early February 2012, the case was allocated to SW2 and a core assessment initiated. SW3 was told by Community Paediatric Nurse2 that Mother visits infrequently, an hour every couple of days and not carrying out basic tasks such as feeding. The plan at hospital was for discharge as baby E was making good progress and now taking 3 hourly feeds. Community Paediatric Nurse2 requested a professionals meeting.

4.4.21 The next day (when baby E was aged 33 days old), SW2 undertook a home visit, the second C&F visit since baby E's birth. Mother, Mr P and child F were present. Mother explained that she tries to visit daily and has started to feed baby E. The Father was said to visit too, to have parental responsibility for child F but not on the birth certificate for baby E.

4.4.22 SW2 liaised with Community Paediatric Nurse2 and explained that Mother did not realise she could visit at any time. SW2 was informed that Mother not visited that day, although Father had done so and stayed for nearly 2 hours.

Discharge meeting at hospital when baby E aged 6 weeks

4.4.23 The health visiting team at the GP surgery were informed of baby E's birth and of the concerns when the baby was aged 34 days old. HV1 was invited to the forthcoming discharge meeting at the hospital NNU.

4.4.24 Community Paediatric Nurse 2 gave SW2 an update (when baby E 5 weeks 1 day old): Mother was not interacting with baby E and did not understand the need to respond when the monitor went off. SW2 explained that the plan was for baby E to go home with a 'professional visiting matrix in place', and in response to expressed concerns about Mr P, SW2 explained 'we had not received any current referral with regards to his behaviour'.

4.4.25 SW2 asked Mother if she wished to bring a family member with her to the meeting and in answer to Mother's query about Father's attendance, explained that as he does not have parental rights, he had not been contacted.

4.4.26 The meeting, when baby E was aged 6 weeks old, was attended by the Named Nurse, a NNU nurse, SW2 and manager, HV1, Mother and MGM. It was planned that baby E would be discharged in a fortnight, having made progress and weighing 2kg.

4.4.27 Father was reported at the meeting to visit frequently and communicate with baby E.

4.4.28 In response to the concerns about Mother's infrequent visiting, she mentioned being fearful of coinciding at the NNU when Father was there and as a result it was agreed that:

- SW2 to contact Father and tell him that 'as he does not have parental rights he can no longer ' visit baby E
- Mother to spend longer periods with baby E on NNU and 'room-in' prior to baby's discharge home
- Mother to register family with local GP and attend her 6 week post natal check (NB according the health visitor individual management review she was already registered at new GP surgery)
- MGM to stay at home following discharge to offer support and advice – and to care for child F before so that Mother could have overnight in hospital
- Visiting matrix to be drawn up when baby E returns home

4.4.29 Following the meeting it was agreed with Mother that she would visit from 9.30 to 16.00 hours daily.

4.4.30 SW2 called Father to inform him he could no longer visit as he did not have parental responsibility and he was advised to seek legal advice about Mother preventing him from seeing child F. The NNU were informed that Father should not be visiting and in response to asking the social worker about a good-bye visit, SW2 explained Father had not requested this.

Next 3 weeks until baby E's discharge

4.4.31 Baby E was discharged home aged 9 weeks and 2 days. In the 3 weeks before this, Mother visited more often and sometimes participated in the care of her child (including one overnight visit), but she still missed several days, sometimes without making any contact with the unit. Overall the hospital individual management review refers to her visits as 'irregular and infrequent', visiting chiefly during the evenings and staying for around 45 minutes. Father did not visit, but contacted the unit for an update.

4.4.32 The social worker informed both the hospital and the health visitor (HV2) that there remained no concerns about baby E's discharge home. HV2 noted that a child in need meeting would be arranged and that SW2 advised that the home was 'smoky'.

4.4.33 It was agreed that follow up would be provided by paediatric nurses for one week and the health visitor subsequently. HV2 informed the GP surgery of baby E's imminent discharge and of the need for Mother to have a post natal check.

4.4.34 Baby E was discharged following Mother staying over for 2 consecutive nights and undertaking the care of her baby. MGM had agreed to stay over for the first few weeks.

4.5 BABY E AT HOME: AGED 9 – 11 WEEKS

Age of baby	Event
9 weeks and 4 days	home visit by Community Paediatric Nurse: baby E making good progress, putting on weight Mr P observed to be angry
9 weeks and 6 days	Mother and baby attended GP for routine post natal
	Hospital discharge summary for baby E arrives at GP surgery
	unannounced social work visit – no-one home
10 weeks	Baby E failed to arrive at GP surgery for immunisations
	unannounced social work visit: Mr P and child F seen – Mother and baby asleep
	SW2 has supervision and plans to hold child in need meeting, inviting other agencies for the date when baby E would be aged 11 weeks and 4 days
	Mother's GP records arrive at GP surgery – transferred by previous GP surgery
10 weeks and 1 day	Health visitor records received from previous GP surgery
	Community Paediatric Nurse visit, baby E doing well, child F appeared to have dental caries
10 weeks and 4 days	Health visitor and Community Paediatric Nurse undertook joint visit – new birth visit
	SW2 visits family. Child F seen with a man outside [later identified as

	Father)
10 weeks and 5 days	Mr P called the SW to state that baby E had a hospital appointment in 6 days, when the child in need meeting was due: SW2 agreed to re-arrange meeting and arranged with other practitioners for it to be the next day
	The health visitor discussed her concerns with GPs at monthly liaison meeting (NB discrepancy with GP individual management review which states this meeting cancelled)
11 weeks	Mother attended GP complaining of being tired and not bonding with baby E

4.5.1 During the first 2 weeks that baby E spent at home there was frequent contact with practitioners as shown in the key dates table above. These consisted of:

- 2 visits by Community Paediatric Nurses alone
- 1 joint visit by Community Paediatric Nurse and health visitor (baby E aged 10 weeks and 4 days) – equivalent of new birth visit but Mother had friend [Mr P's sister] and her children present, so it was not possible to undertake the in depth assessment required
- 2 GP contacts - Post natal appointment and Mother complaining of being tired and not bonding
- 2 unannounced social work visits – succeeded in seeing Mr P and child F on second occasion, but no-one home the first time
- 1 planned social work visit when Mother and baby E seen (and child F outside with a man)

4.5.2 In this short period baby E seemed to be making good progress in terms of feeding and putting on weight, but the following concerns were identified by the health practitioners:

- MGM only stayed for 2 days, instead of the planned first few weeks
- Mr P was described as annoyed and angry during one home visit, and as having an abrupt and intimidating manner - the Mother was observed to answer questions in his presence but not to chat
- Child F had dental caries and it this may have indicated neglect of her dental health
- Baby E did not attend for immunisations
- Mother did not keep the requested feeding chart
- Possible learning difficulties preventing Mother from fully comprehending advice
- Observed that friend reminded Mother of need to feed baby and then friend fed the baby
- Health visitor advised Mother to request repeat prescription for baby E but discovered she did not collect the prescription from the GP surgery

4.5.3 In addition, although not articulated at the time as a concern the following observations / comments were noted:

- Mr P acknowledged to the social worker he was living in the home (the notes refer to 'no parenting concerns in respect of [Mr P] living with [Mother], however it may be early days')
- Mother told the health visitor ((baby E aged 10 weeks and 4 days) that the social worker had advised that child F not left alone with Mr P
- Mr P was observed by social worker to be caring for child F and reported by pre-school to have brought child F in one day

- Mother told her GP she was 'tired all the time', fearing she may not be bonding well with baby E and wanting to run away (baby E aged 11 weeks) – GP arranged for blood tests which showed mild anaemia and information to be provided to the health visitor that baby E home

4.5.4 It is noteworthy that when Mother and baby attended the new GP for a routine postnatal check (baby E aged 9 weeks and 6 days), the GP had no information at all on either Mother or of baby E's existence. Mother's medical notes had not yet arrived at the new surgery and the hospital discharge summary, posted to the GP 2 days after baby E's discharge only arrived at the surgery the day Mother attended, but not scanned into the notes until the next day.

4.5.5 However, even if seen by the GP this would not have succeeded in conveying the concerns: it refers to 'social issues discussed with CP nurses' and 'Referral made to Social Services for continued support at home', but provides no details of the 'social issues' or the outcome of such concerns. There is no other documentation by hospital staff of any other communication with the GP.

4.5.6 There was liaison between health practitioners and social workers regarding the concerns. In the social workers supervision (baby E aged 10 weeks) a child in need meeting was planned for when baby E would be aged 11 weeks and 4 days old. SW2 invited agencies to the meeting, including the pre-school leader, who said that child F settled in well, was happy and popular. There were some issues about cleanliness and head lice, which had been discussed with aunt. Mr P was seen on one occasion 2 weeks earlier when he brought child F into pre-school.

4.5.7 There was no record of any contact with the children's Father but when baby E was aged 10 weeks and 4 days, SW2 and a student social worker visited and child F was seen outside with someone described at the time by Mother as a male friend, but subsequently established to be Father.

4.5.8 Along with providing false information about Father's identity that day Mother also reported Mr P as completing a parenting assessment. At that point it was assumed to be in relation to his child with Ms Q, but subsequently the social worker discovered that this was not the case.

4.6 INITIATION OF CHILD PROTECTION ENQUIRY

4.6.1 When baby E had been home 2 weeks and 2 days (aged 11 weeks and 4 days) a child protection enquiry (s.47 enquiry)[7] was initiated.

Age of baby	Event
11 weeks 4 days	Home visit by health visitor and bruising observed on baby E
	Duty social worker and social work assistant visit home: no-one there
	13 .00hours: office appointment : Mother and baby E seen
	13.29 hours: Police contacted by social worker
	15.30 hours: Sergeant called C&F
	17.50: paediatric assessment: bruising unlikely to be consistent with explanation
	19.45 Baby E allowed home that evening with Mother's written agreement to exclude Mr P from household chores
11 weeks 5 days: 1 day after bruising discovered	Police informed of outcome of medical and undertake checks as requested the previous day
	Paediatric report received by C&F which states more likely to be non accidental injury
	16.45 DSW and SWA explain medical findings in a home visit and obtain agreement for Mr P to be excluded from the household, using a written agreement

Discovery of bruise

4.6.2 Health visitor 2 made a planned home visit that day and observed that baby E had a small round bruise to the forehead and another small bruise to the right hand side of the face, near the mouth. When asked, Mother explained that Mr P had been feeding baby E, who was accidentally hit by Mr P's belt.

4.6.3 When Mr P came into the room he ignored the health visitor and banged a broom around. Although he did not say anything the health visitor described his demeanour and behaviour as 'menacing' and the atmosphere as 'intimidating'. Mother was noted to appear anxious and kept glancing at Mr P. This had the effect of inhibiting the conversation and the health visitor left, observing on her exit a battered baseball bat.

Referral to C&F

4.6.4 The health visitor alerted the social worker to the bruising and her concerns about the explanation provided. She also telephoned the Mother to explain the referral to C&F and communicated with the paediatric nurse, her team leader and health visitor colleagues. She did not contact the GP or ask Mother to take baby E for medical attention, as she identified that this would be the social worker's responsibility to co-ordinate as part of child protection enquiries. The health visitor was not informed of any outcome to this child protection referral and was not invited to any strategy discussion or meetings. She tried to discover the outcome, calling C&F and leaving messages over the next days. The social worker did though communicate with the paediatric community nurse.

4.6.5 Both SW2 and the team manager were on leave. The ATM immediately sent out a duty social worker (DSW) and a social work assistant to the family home, but there was no-one

[7] Section 47 Children Act 1989

there. Mother was contacted by telephone, and came into the office for 1.00pm where she was seen by the duty worker and social work assistant.

Liaison with police

4.6.6 The DSW contacted the police CAIU team, in the expectation that checks would be undertaken in preparation for a strategy discussion. The police called the assistant team manager (ATM) two hours later. There is a different perception of the telephone communication that took place between the ATM and the police sergeant. The ATM described (in interview for the C&F review) that the officer appeared not to want to progress the matter any further and with the ATM insisting on the need for an urgent paediatric assessment to evaluate the bruising, agreement was reached for a 'single agency investigation'. The TVP individual management review indicates that the police officer thought a 'joint' investigation was being initiated, albeit leaving the paediatric examination to C&F.

Paediatric assessment

4.6.7 Baby E was seen on the paediatric decision unit (PDU) by the locum consultant paediatrician. Mother explained that the previous morning baby E rolled onto Mr P's belt when he was feeding the baby. She usually does the feeding, but on this occasion when she woke up around 09.30 hours Mr P informed her baby E had already been fed. Apart from the facial bruising the physical examination was recorded as normal. The paediatrician concluded that 'the force required to produce these bruises are unlikely to happen from the baby rolling over' and 'less likely to be accidental injury'.

4.6.8 This was discussed with the consultant in charge, who reviewed the case. The DSW understood that without seeing the belt they could not conclusively state the bruises were non accidental and it was agreed for a strategy meeting to be convened as soon as possible and the belt to be located.

4.6.9 Following a telephone discussion with the ATM it was decided that:

- Mother and baby E would go home with a written agreement excluding Mr P from any childcare tasks
- That a written report be provided by the consultants 'as evidence for a strategy discussion with the police'

Follow up the next day: second written agreement

4.6.10 The DSW tried the next day to arrange a strategy meeting but the paediatrician was not available, but highlighted the view that 'the baby is at high risk'. The police were informed of the outcome of the medical and a strategy meeting requested. The police 'checks' requested the previous day were then initiated.

4.6.11 The paediatric written report was received by C&F in the afternoon:

'Baby E is a 11 week old ex-premature baby who has two new bruises over left forehead and right cheek 7cm apart from each other. Given the history it is not possible to establish the mechanism of the injury. The force required to produce these bruises unlikely to happen from baby rolling over. It is less likely to be accidental injury.'

4.6.12 (C&F individual management review) refers to the report confirming that Mother's:

'explanation for the injuries cannot be substantiated: the bruises were unlikely to happen from this explanation. Therefore it is more likely to be non-accidental injury.'

4.6.13 The DSW and social work assistant visited the family home later that afternoon, explained the results of the medical report and suggested that Mr P leave the property during the child protection enquiry. He suggested that child F caused the bruising. Eventually and reluctantly Mother signed the written agreement excluding Mr P from the household. DSW and SWA explained the situation to Mr P and he left the home with them.

4.7 JOINT INVESTIGATION

Age of baby	Event
11 weeks 6 days: 2 days after bruising discovered	10.00 strategy meeting: agreed police photo injuries, interview Mr P and examine his belt
	Joint visit undertaken. No Scenes of Crime Officer available to take photographs
12 weeks old – 3 days after bruising identified	Police officer visited home and noted that bruises no longer visible Mother provided a statement with a variety of explanations for the bruising
12 weeks old, 1 day – 4 days after bruising identified	Police visit Ms Q
12 weeks 4 days – 1 week after bruising identified	Home visit by social worker and student social worker: Mother announces intention to move to London with Mr P Member of the public allege that Mr P's use of drink and drugs behind baby E falling off Mr P when he fell asleep: police plan to take a statement
12 weeks and 6 days: - 1 week and 2 days after bruising identified	Community paediatric nurse visited: communicated to health visitor that baby E well
	Police arrested and interviewed Mr P: provided various possible explanations for bruising: plan discussed with social worker for skeletal survey and strategy meeting – latter discussed with a manager in C&F
13 weeks and 5 days – 15 days after bruising identified	1st liaison between social worker and health visitor since start of s.47 enquiry – first mention of possible child protection conference
14 weeks old – 17 days after bruising identified	Strategy meeting arranged for 4 days ahead

2 days after bruising was identified: strategy meeting

4.7.1 A strategy meeting was held 2 days after the discovery of the bruising, between C&F and TVP and from this point a criminal investigation was initiated, so the single agency s.47 enquiry became a joint investigation by police and C&F.

4.7.2 No other agencies were invited to the strategy meeting, where Mr P's history was shared of involvement in domestic violence with Ms Q, that one of her children received an

unexplained injury whilst in his care, that Mr P was still likely to be in a relationship with Ms Q and that her children remained subject to child protection plans.

4.7.3 At the request of the social work manager the police agreed to take photos of baby E's injuries, interview Mr P and examine his belt.

4.7.4 A joint visit was undertaken later that day when baby E was seen at MGM's home. SW2 re-iterated that Mr P was not to have any contact with the children until the investigation was completed. There was no Scenes of Crime Officer (SOCO) available so the photos were delayed. The plan was for this to occur the next day.

Investigation into cause of bruising

Next day: 3 days after bruising identified

4.7.5 On the 3rd day of s.47 enquiries Mr P telephoned the social worker suggesting that baby E could be experiencing 'blue spot'[8]; this possibility was followed up with, and discounted by, the paediatrician, and this confirmation was received in writing 19 days after bruising indentified (see 4.8).

4.7.6 A police officer visited Mother and baby that day and noted that the bruises were no longer visible. SOCO explained that they had no photographic equipment able to highlight injuries that are invisible to the human eye. Instead it was decided the officer should take digital photographs (with a scale) of baby E and of the scene. This was undertaken 4 days later, one week after the injuries occurred.

4.7.7 Mother provided a statement that day which provided various explanations for the bruising:

- Mr P told her his buckle caught baby E's face
- Baby E born with 'blue spot'
- Mother may have caused the bruising herself when winding baby E, supporting the baby's face

4.7.8 The social worker recorded that police told her the Mother would have Mr P back, even if it was found he had caused the injuries. She also alleged the children's Father had previously bruised child F.

4.7.9 The police agreed to interview Mr P 6 days later and for him to bring in his belt. C&F were notified and re-iterated that Mr P should remain outside the family home until the investigation was complete. This was confirmed with Mr P by the social worker, but Mr P subsequently left a message that he was at the flat calling police due to threats from his brother and partner. The children were stated to be with MGM.

4 and 5 days from after bruising identified

4.7.10 The police continued to be involved with the family over the next days, when there were disputes and texted threats between Mr P, Mother, her sister and Mr P's relatives, apparently due to conflict over possessions and money. Police dealt with this by completing 'Domestic Violence Risk Indicator Form' with a grading of standard risk, sent to other agencies.

[8] Blue-grey or bruised-looking birthmarks which are present at birth. They are more commonly seen in darker-skinned people and may last for months or years, but usually disappear by the age of four. They are completely harmless and may be mistaken for a bruise.

4.7.11 The police also visited Ms Q who said she had never seen Mr P being violent to the children, although one of her children had made comments about him causing injuries to siblings.

1 week after bruising indentified

4.7.12 The social worker and student social worker found the family at home following 2 unsuccessful visits the week before. Mother referred to child F's attempt to pick baby E out of a chair, as well as alleging that the children's Father used to be violent towards her.

4.7.13 Worryingly, Mother mentioned her intention to move to London with Mr P and during the visit, he turned up outside the flat wanting his passport and driving license.

4.7.14 The same day a member of the public alleged to the student social worker that Mr P had been smoking and drinking heavily (including according to the TVP individual management review using cocaine), and this was behind baby E being hurt.

8 days after bruising identified

4.7.15 The social worker discussed with the community nurse that baby E was constipated and that the nurse should keep the appointment as Mr P would not be home as he had an appointment at C&F, and that Mother was expecting the nurse.

4.7.16 When Mr P came to C&F for the purposes of the core assessment he told the social worker that he had been in care himself for 'numerous years'. He also mentioned that the nurse had cancelled the visit that day. The social worker took this up and the nurse visited the next day, communicating with the health visitor that baby E was well.

9 days after bruising identified

4.7.17 1 week and 2 days after the bruising was discovered, the police arrested and interviewed Mr P, when he provided 3 possible explanations for baby E's injuries:

- His buckle caught baby E's face
- Baby E born with 'blue spot'
- Child F caused the injuries

4.7.18 Mr P was released with bail conditions prohibiting interfering with witnesses or otherwise obstructing the course of justice. The conditions were he must live at a designated address and that he must not have unsupervised access to a child under the age of 16 years.

4.7.19 The police officer updated the social worker with the outcome of this interview and (according to the police individual management review) they discussed the potential for a:

- Strategy meeting
- Skeletal survey for baby E to rule out any previous injuries – it is not clear if this was ever progressed

4.7.20 The same day they spoke to the member of the public and arranged to take a statement the next day. The statement contains the allegation that Mr P had admitted dropping the baby onto the floor whilst he dozed off. He was said to drink alcohol during the day and be a heavy cannabis user. The statement also covers his intent with mother to blame the bruising on the 3 year old and that mother was prioritising her relationship with Mr P over her children.

4.7.21 The social worker spoke to Mother, who questioned the need for bail conditions and spoke about moving soon.

4.7.22 In the absence of her own team manager, the social worker discussed with another manager and Ms Q's social worker the need for a follow-up strategy meeting to decide about holding an initial conference.

15 days after bruising identified

4.7.23 The next liaison between professionals was 6 days later, when the health visitor and social worker spoke. The health visitor was updated on the bail conditions and the social worker told about Mr P's presence the day the health visitor found the bruising. The social worker planned to speak further to her team manager about a child protection conference, when her team manager returned.

17 days after bruising identified

4.7.24 2 days later, the social worker arranged a strategy meeting for 4 days ahead (i.e. 3 weeks after bruising identified), inviting CAIU, health visitor and child protection nurse from the hospital. The health visitor reported that there had been no-one home when she had tried to visit the previous day but that the community paediatric nurse had visited the previous week and there were no longer issues with constipation and baby E was gaining weight.

4.8 FURTHER INJURIES TO BABY E

Age of baby	Event
14 weeks and 2 days old – 19 days after bruising identified **Friday afternoon**	**14.00 hours**: Home visit by health visitor. Mother feeling low and baby E unwell, not feeding, and crying on movement. GP appointment made for 16.30
	14.55 hours: the health visitor went to the GP surgery and tried to get an earlier appointment, but this was not possible
	15.30 hours: Health visitor returned to the home and arranged for the Mother to take baby E straight to A&E
	16.30 hours: health visitor informed the student social worker of what had occurred, including that child F had mentioned Mr P had smacked baby E
	C&F receive email from paediatrician making it clear that previous bruising could not be Mongolian Blue spots as these do not appear and disappear quickly, are present from birth and usually on the back and trunk
	16.10 hours: Baby E arrived at A&E and seen by doctor at 17.20 hours and by paediatric registrar at 18.30 hours.
	17.00 hours: social worker tells health visitor that the previously arranged strategy meeting on Monday will proceed and baby E to be kept in hospital over the week-end
	21.15 hours: baby E arrived on ward – Mother left within 5 minutes

14 weeks and 3 /4s days old – 20/21 days after bruising first identified	**Week-end** Baby E's head circumference increased and noticed that right leg not moving. Baby in pain when nappy changed. X-ray at hospital showed possible old fracture or reaction secondary to infection
14 weeks and 4 days – 22 days after bruising indentified	**Monday** **Morning :** X-ray reviewed and old fracture diagnosed
	14.00 hours: strategy meeting Mother to have supervised contact only. Baby E not to be removed from the ward and not to be left unattended

Health visitor concerned at home visit

4.8.1 Following her home visit 19 days earlier, when baby E had bruising, the health visitor returned to the family home on a Friday afternoon with a nursery nurse to see baby E again. They had tried unsuccessfully 2 days earlier, but on this occasion Mother was home with baby E and child F.

4.8.2 Mother was perceived to be tense, in a low mood, and expressionless in her interaction with baby E. She spoke of feeling 'down', sleeping and eating badly. Critically she also spoke of not bonding with her baby and not having much time for either of her children. She explained that this may be because they looked like their Father. Mother also mentioned that social care was taking too long to reach a decision about the bruising and she could not cope on her own. The health visitor advised Mother to see her GP because of her low mood, and agreed to review her mood using the Edinburgh Postnatal Depression Scale (EDPNS) at next visit[9].

4.8.3 Mother reported that Baby E had not had a feed since 23.00 the previous night and had not opened bowels for almost a week. The baby was described as mostly sleeping. The health visitor examined baby E and noted a response to being spoken to, with no signs of rash, visible marks or indication of dehydration. When Mother tried to feed her baby, she was observed to only hold the teat to the mouth and not encourage sucking, so the health visitor tried and was concerned that baby E cried on movement. The health visitor immediately made a GP appointment for that afternoon.

4.8.4 During this time the nursery nurse heard child F say 'It's because [Mr P] smacked him'. She informed the health visitor when they left the flat, so the health visitor went to the GP surgery to try to get an earlier appointment.

4.8.5 When this proved impossible the health visitor, after consulting colleagues, decided that baby E should go to A&E at the local hospital, and returned to the home to inform Mother.

4.8.6 The health visitor liaised with A&E, speaking to the Staff Nurse to provide background information, including the previous concerns with regard to baby E, albeit not the comment that child F had made about Mr P. This was though communicated to the student social worker at C&F at 16.30.

[9] Edinburgh Postnatal Depression Scale is a questionnaire given to new mothers around 8 – 12 weeks after the birth to assist health visitor's to assess mood

4.8.7 The C&F team manager decided that as baby E would be in hospital over the weekend the planned strategy meeting arranged for the Monday could take place and include the new concerns about baby E's health and Mother's mental health.

Baby E admitted to hospital

4.8.8 Mother and Mr P brought baby E to A & E. The community paediatric nurse attended A&E to provide the history and saw baby E asleep in Mr P's arms. He explained he had rushed back from London, and spoke of the baby's constipation over 4 weeks and swollen stomach.

4.8.9 Baby E was seen by the A&E doctor and the Paediatric Registrar, who decided to keep baby E in hospital for observation. Mother left the ward within 5 minutes of arrival (21.15) and the nurse noted she had no interaction with her baby. Baby E appeared unsettled and disinterested in feeds, crying as in pain. Mother had stated that her baby was not on any medication, despite having been given 2 medicines for reflux prior to discharge from NNU.

Over the week-end

4.8.10 Overnight and on the Saturday it was observed that baby E became distressed during feeds, but accepted feeds better when a smaller teat was used. Mother visited during the Saturday and left around 18.00 hours without telling staff.

4.8.11 At the Ward round that day the Specialist Paediatrician noted the improvement in feeding and that baby E moved all four limbs during sleep. Later baby E was unsettled, so at 22.40 hours, a paediatric junior doctor reviewed baby E and observed baby E cried on handling with a right leg tender to palpitation, but without swelling. Following discussion with the Registrar baby E was sent for x-ray and subsequently on the Saturday evening it was noted that baby E was not moving the right leg spontaneously. Nursing observations the next morning included 'right leg looks slightly larger than left'.

4.8.12 On the Sunday, a doctor shared the concerns with Mother: baby E was not moving the right leg, was crying in pain during nappy changes and x-rays showed an old fracture or reaction to infection. Mother said she had not noticed any painful response or had any concerns regarding the right leg, that no-one could have hurt baby E, that she had looked after her baby all the time and that child F does not hold the baby.

4.8.13 It was explained to Mother that there needed to be further investigations to establish if there might be an infection and to establish the cause of baby E's head circumference having increased.

4.8.14 At one point on the Sunday, a man claiming to be baby E's father came on the ward. The hospital individual management review refers to him having an aggressive manner, demanding what had been done to baby E since coming into hospital with reflux. Mother intervened and went to speak with him, taking child F with her. She returned on her own and explained the man was baby E's uncle, but later told a nurse this was her partner who was not allowed contact with baby E. Baby E was transferred to the high dependency unit for closer observation.

4.8.15 Mr P contacted the Out of Hours social care team to complain that injuries may have been caused by hospital staff. After being calmed down by the social worker he apologised for his anger, stating that his 'wife' was being accused of causing injury to baby E.

Monday

4.8.16 Unaware of the concerns and hospital admission of baby E, the police DS updated records after discussion with the Officer in Charge of the investigation into baby E's bruising. This stated that:

- Suspect arrested and interviewed, providing various non intentional accounts of how baby E might have incurred the bruising
- Mother had provided a statement where she may have caused the bruising holding baby E's head during winding
- Injuries 'look like 2x fingertip marks (small in size) on child's forehead'
- Allegations made by member of public that baby E dropped by Mr P whilst under the influence of drugs
- All accounts were considered possible, so it was decided it did not meet threshold 'for a realistic prospect of a conviction'
- The OIC to present need for a child protection plan at the strategy meeting that day, due to 'lower level' neglect issues, with child F 'boisterous' and not properly supervised

4.8.17 Meanwhile at the hospital, the Orthopaedic and Radiologist Consultants reviewed the x-rays and both were in agreement that the right femur had been fractured, with the injury likely to be 2-3 weeks old. A skeletal survey, CT head scan and ophthalmology investigations were arranged.

Strategy meeting

4.8.18 The outstanding strategy meeting from the previous joint investigation was held as arranged that afternoon on the children's ward of the local hospital and attended by the team manager, 2 social workers, student social worker, health visitor, paediatric registrar, police CAIU and the local authority solicitor. The police only learnt about the hospital admission when they attended the meeting.

4.8.19 At the meeting possible causes for the increased head circumference were discussed as baby E having been shaken (this was subsequently confirmed).

4.8.20 The meeting agreed:

- Health plans for further investigation via a CT scan and full skeletal survey
- Legal proceedings to be issues
- Police to consider extension of Mr P's bail conditions
- Child F to be placed with MGM

4.8.21 Later that day the social worker and team manager visited the maternal grandparents home, where they saw Mother, Mr P and child F. The decisions of the strategy meeting were explained and a written agreement was signed that arranged for:

- Child F to reside with MGM
- Baby E to be accommodated by the local authority (section 20, Children Act 1989)
- Contact to be supervised (this did not include Mr P who was told that he would not be allowed to visit as he did not have parental rights)

4.8.22 The understanding at the hospital (as reflected in their individual management review) was that Police Powers of Protection were subsequently taken. The police individual management review author found no evidence that this occurred, but that arrangements

were made for this to happen should any family members try to discharge baby E from hospital or take child F from MGM.

5 OPPORTUNITIES FOR INTERVENTION

5.1 INTRODUCTION

5.1.1 The practice on this case largely centres around the identification of risk and the quality of assessments as multi-agency intervention with the family was over a short period of time and did not progress beyond this stage, except for the provision of universal services by the GP and midwifery.

5.1.2 The following events over the period of the review led to critical opportunities for practitioners to intervene effectively:

- Mother's second pregnancy confirmed: August 2011
- 5 domestic abuse episodes: commencing late summer 2011
- Birth of baby E
- Discharge meeting at hospital
- Core assessment
- Bruising to baby E's face
- Baby E's admission to hospital

5.1.3 For each of these events this chapter considers the practice including the identification of risk, the assessment and the consequent planning. The next chapter will address the specific terms of reference for this review.

5.2 MOTHER'S SECOND PREGNANCY CONFIRMED: AUGUST 2011

Assessment: no risk factors identified

5.2.1 There were early risk factors relating to Mother's parenting abilities from the knowledge of her parenting of child F. The first health visitor's record shows that Mother felt low after the birth of her first child and there were concerns about the poor attachment and interaction between Mother and child. As a result the family were offered enhanced health visiting service, but, Mother did not engage with support services and much of the care of child F was undertaken by MGM and / or Father.

5.2.2 In the second pregnancy Mother told the midwife she had suffered with post natal depression previously but had not had any treatment. She was not identified as 'vulnerable' and no safeguarding concerns were notified to the health visitors, so no further action was taken by that service before baby E's birth.

5.2.3 The health overview report judges that the midwifery assessment was of a good standard but could have been strengthened through greater exploration of the role of the Father and through making routine enquiries about domestic abuse. The latter was avoided as a friend was present and to avoid such omissions the midwifery management review has described new standardised arrangements to ensure such questions are asked, involving updated training and a revised Domestic Abuse guideline.

5.2.4 Such changes would have been unlikely to have made any change in this case given the very limited evidence of previous domestic abuse.

5.2.5 The risk factors in relation to Mother's early parenting of child F were not identified by midwifery or by the health visiting service during the pregnancy. Although she had not

been identified as suffering from post natal depression with her first child it would have been helpful for the midwife to have been aware of the health visitor's concerns i.e. understanding of mother having felt 'low', the 'poor attachment' observed between Mother and child and that child F was cared for by others. Considerations of this nature may have led to the identification of Mother as 'vulnerable'.

5.2.6 The review panel had considered the extent to which such concerns by health visitors are notified to midwifery. Midwifery use a liaison form to share concerns with health visitors, but do not have access to the health visitor records to be aware of any historical parenting concerns with siblings unless these are identified by the GP or parents in the booking in process. The Health Visitor may not have been aware at the time of the pregnancy in order to share any concerns, but the systems have changed and the health visitor would now know. What is less clear is if such previous history held by health visitors is communicated to midwifery to be factored into the midwifery vulnerability assessment.

5.2.7 The Healthy Child Programme recommends all pregnant women should have antenatal contact from the health visitor, but this is in early days of implementation and, according to data from this programme (quoted in the health visiting management review), 22% of health visitors in Bucks were managing to see vulnerable antenatal women identified by midwives. In this case Mother was not even identified as 'vulnerable'.

LEARNING
The current system for midwifery identification of a pregnant woman and her foetus as 'vulnerable' does not ensure that all relevant information from health visitors is included in such assessments

5.3 DOMESTIC ABUSE EPISODES: LATE SUMMER / AUTUMN 2011

5.3.1 The police management review provides a detailed analysis of the service's response to the repeated allegations of domestic violence within the Q household during the review period. In all cases the police responded to the risk of domestic abuse and the initial DASH (standard risk assessment) for all the incidents were completed in a timely way. However in 2 of the 5 incidents the final grading was lower than appropriate in the circumstances and in 1 instance no new assessment was undertaken. Moreover on one occasion whilst officers focused on the adults involved, they did not immediately consider the welfare of the children.

Lack of focus on IMMEDIATE risk to children (incident 4 of the 5 incidents)

5.3.2 On one occasion the Mother called police leaving her children alone with Mr P who had allegedly been drinking and was violent. Mr P himself called shortly after that to say he had left the children alone. It took the officers 25 minutes to check on the children, following intervention by the Control Room Operator to remind them the children were alone.

Inappropriately low grading of risk (grading of 2 out of 4 incidents)

5.3.3 The first inappropriate grading was when a Risk Assessor downgraded the risk from high to medium on the basis of both adults being known for some time, that the incident suggested the 'victim' had not ended the relationship as previously reported and the suspect had previous opportunity to cause serious harm but had not done so. The senior Officer in charge of the Protecting Vulnerable People (PVP) teams has appropriately identified that this decision was wrong as it did not take into account the number and

severity of risk factors, the escalating pattern of behaviour and the lack of victim engagement.

5.3.4 The second incident raised particular issues in relation to the grading of risk when the victim refuses to complete the risk assessment form, and when there is no full research into the history of the family involved, including child protection incidents. This resulted in a lower grading of risk than was appropriate, rather than recognition that this may in fact indicate a higher level of risk.

Omission of new risk assessment (1 of 5 incidents)

5.3.5 A further issue emerged due to the lack of a new risk assessment when a new incident occurred within days of a previous incident, despite Mother on this occasion saying Mr P was 'scaring the life out of her'. Moreover the incident demonstrated an escalation from alleged text 'threats' to alleged presence on the premises and throwing a brick in the garden. The rationale for this lack of new assessment was on the basis of no new threats. Given that the allegation indicated a possible attempt to action the threats this perception is a major concern.

Outcome

5.3.6 Had assessments been undertaken on each occasion, taking into account the history of household members and with an understanding of the *increased* risk when the victim is not engaging with police, it is likely that the last risk assessments would have resulted in a 'high' grading, so Mr P's presence in a household may have been perceived as a higher risk subsequently by police and other agencies.

LEARNING

There is a need to ensure that TVP staff undertaking risk assessment work in relation to domestic abuse understand the need:

- To ensure that any assessment takes full account of history of household members, both in relation to domestic abuse and child protection
- To raise the risk level in circumstances when the victim is not engaging
- For a new risk assessment for every incident regardless of the content of the allegations or the date of the previous incident

5.4 BIRTH OF BABY E

5.4.1 The emergency services all acted promptly and sensitively to assist and support the family following the premature birth of baby E. In such unusual and critical circumstances there is inevitably some confusion and to the credit of all the staff involved within the ambulance service, the police and the local authority out of hours team attention was paid to the welfare of all family members, albeit following some confusions and misunderstandings.

5.4.2 The management reviews from the police and adult social care have looked in detail at what occurred that night in an effort to learn from this unusual incident.

5.4.3 There is no management review from the ambulance service but they clearly assessed the risk to Mother and baby and acted promptly in calling the police and taking first baby and then Mother to hospital.

Risk assessment and planning in an emergency at night

5.4.4 However, the transcript of the calls between the police Control Room Operator and the OOH social worker that night demonstrates the confusion that existed that for staff struggling to identify potential risks, make assessments and immediate plans for the safety of the children.

5.4.5 Child F was removed from the scene by relatives without any consideration whether any basic checks should have been taken or even contact details obtained.

5.4.6 The decision to contact OOH was appropriate as was the recognition by police that this could become an 'unexpected death'. From this point the management reviews explain the 'miscommunication' that arose based on flawed information and assumptions, but which did in fact succeed in alerting those involved to the potential risk regarding Mr P.

5.4.7 The call was made to the social worker by a Control Room operator who asked what was known about Mother and her partner, but without providing the context or explicit purpose of the enquiry, so as to inform the extent of the search. It is likely that this was probably not fully understood by the caller her/himself.

5.4.8 Further probing by the social worker did establish the caller's assumptions of the relationship of Mr P to the baby. The social worker provided the information that Mr P was known to C&F at a different address, that he was on police bail but that his child was not subject to a child protection plan. This last piece of information was erroneous as the child was subject to a plan and it is understood that this was 'individual error' exacerbated by the complications of the electronic care record and not accessing the full information available [see 6.14]. The OOH social worker advised that baby E should be kept in hospital overnight.

5.4.9 Further research by police provided the details of the domestic abuse and child protection concerns which would have justified the social worker's advice. However there was no planning between the 2 agencies about how such an arrangement would work in practice and what to do should there be an attempt to discharge the baby. In fact no police officer spoke to the out of hours social worker, leaving such important discussions in the hands of a control room operator.

5.4.10 Moreover the hospital were not part of this planning but were informed that Mr P could not visit without Mother.

LEARNING
Communications between out of hours services may involve unknowns due to the emergency circumstances, but the police service need to be clear what is being asked of the out of hours social workers and the police officers need to undertake direct communication when the situation is complex.

Immediate risk assessment by C&F

5.4.11 There was initially good work undertaken within C&F the next day: collecting information from the police, the social worker for the Q family, the hospital, Mother herself and MGM.

5.4.12 Between C&F and police, the risk factors were identified including Mr P's involvement in domestic abuse, alleged child protection concerns and the very recent start to the relationship, along with fact that other children were subject to a child protection plan, in part due to the potential risk of contact with Mr P. Moreover the police officer shared

concerns about Mother's limited capacity to care for her baby, subsequently supported by hospital staff's observations.

5.4.13 Mother additionally alleged that baby E's Father did not want any contact with the baby, was undependable and had previously slapped child F on the face. This allegation was never explored further to understand if there was any risk to the children from Father.

5.4.14 At this point there was sufficient suspicion of the risk of significant harm to the children in the household for a strategy meeting to be convened, to consider a s.47 enquiry and possible initial child protection conference. This did not happen.

Planning

5.4.15 In response to the identified risks associated with Mr P, the social worker made it clear verbally to Mother that child F should not be left in the sole care of Mr P. However, there is no evidence that:

- It was made clear what would happen should Mother not keep to this agreement
- This was put in writing
- That other agencies were informed of this

Initial assessment within C&F

5.4.16 The initial assessments (one for each child) undertaken by the first social worker over 10 days commencing the day after the birth. The C&F individual management review refers to these assessments as detailed, combining all the information from the agencies and the history of concerns about Mother as a parent, with the judgment she was a vulnerable adult as well as the risk from Mr P. However, the GP was left out of the information sharing and collection.

5.4.17 The assessment was holistic and identified risks, but omitted exploring the critical report from child F's pre-school that the premature birth had allegedly been a result of a fight. This allegation, along with the other risks identified should have resulted in a strategy meeting at the hospital to decide if s.47 enquiries should be initiated and a criminal investigation launched.

5.4.18 Instead there is no evidence this allegation was shared with the police or other agencies and there is no mention of follow up with the person who made the allegation.

5.4.19 The lack of a strategy meeting meant the loss of the opportunity to try and fully understand the circumstances behind baby E's premature birth and to discuss in a multi-agency arena the concerns that were quickly emerging, so as to implement a formal plan of support.

Planning

5.4.20 The plan from this initial assessment was to transfer the case for a core assessment by the Assessment & Intervention team. In the meantime there was no re-iteration of any support plan and there was a 2 week delay in the core assessment being initiated, during which the concerns increased about Mother not visiting her baby regularly in the Neo Natal Unit.

5.4.21 Whilst this was a useful initial assessment, the lack of any associated plan for further specific assessment and support, other than a core assessment meant that the impetus on the case was lost whilst waiting for transfer. Despite doubts about Mother's ability to care

for her premature baby, there was no rigorous planning to assess her ability to manage this.

LEARNING

A strategy meeting should have been convened at the hospital from the outset given the level of risk identified by Mr P's presence in the household, the concerns about mother's abilities and the information from the pre-school of an allegation that the premature birth was the result of a fight. It is important that C&F learn *why* staff did not understand the need for this, as the management review has not explained this.

The individual management review does point out the systemic problem related to the 'standard workflow' if practitioners want to convene an initial child protection conference without a strategy discussion and a s.47 enquiry first. This may indeed be a problem, but in this case there is no evidence that staff had even recognised the threshold had been reached. Hence there remains an urgent need to undertake further work to establish the extent this may be a systemic issue.

5.5 HOSPITAL DISCHARGE MEETING

5.5.1 The hospital discharge meeting when baby E was aged 6 weeks was the first multi-agency meeting held. Its focus though was on planning around baby E's imminent discharge as opposed to identifying risks and assessment. The change in social worker may have involved a loss of familiarity with the concerns that had emerged over the previous weeks.

5.5.2 This meeting was used to clarify with Mother the need for her to visit regularly but without developing an understanding about why she did not visit regularly and why she had difficulty taking an interest in baby E's care – this was in contrast to the Father's more involved parenting behaviour.

5.5.3 Mother kept providing different explanations about her lack of visiting. This included telling the social worker she did not know she could visit at any time and staff on the ward that she had childcare problems. At this meeting her explanation of being fearful of encountering the children's Father was accepted and the decision taken to prevent his contact. The management reviews do not explain why staff tended to accept Mother's word without question, nor explain how they felt able to impose a decision which had no legal basis. This is discussed further in 6. 5.

5.5.4 The risks associated with Mr P were not addressed on this day and Father was not invited to attend the meeting. This is also discussed in 6.5.

5.5.5 The hospital management review author has confirmed with staff that they felt satisfied with the plans for baby E to be discharged to baby E's home. Although the visits had been irregular and Mother displayed little interest in the care of her baby, staff were satisfied that there were 'no other specific concerns' about her care and were 'reassured that social care had carried out a core assessment on the family's support network and there was a clear strategy in place to monitor as well as support the mother'[10].

5.5.6 The plans made that day were kept by professionals, but Mother did not visit her baby daily for long periods as planned (albeit more than she had previously) and MGM only stayed

[10] Buckinghamshire Healthcare Individual Management Review, 2012

with the family for 1 or 2 days post hospital discharge, as opposed to the planned 2 weeks. There was no contingency planning for such circumstances and no professional response.

LEARNING
There are dilemmas for staff when there is recognition of concerns but a view that these are not sufficiently specific grounds for escalation into the child protection threshold. However, such concerns related to mother's ability to understand how to care for her baby as well as her ability to develop a bond with her child. These are basic and could have been more effectively assessed during baby E's period in hospital than they could have subsequently been monitored at home.

5.6 CORE ASSESSMENT

5.6.1 The core assessment commenced 2 weeks after the initial assessment was completed, shortly after the case was allocated to the next social worker. It took over 3 months to be completed and was overtaken by the child protection enquiries.

5.6.2 The content was descriptive and insufficiently analytical of the information obtained. The management review author has helpfully ascertained that the practice in Bucks is for the social worker to undertake the core assessment without explicitly asking for contributions from other agencies, although using information that is provided. Other agencies are not involved in the analysis but come together usually following the completion of the assessment in a Child in Need meeting, when plans would be agreed based on the outcome of the assessment.

5.6.3 The lack of such participation limited the process of challenge that needed to occur given the continuing concerns about mother's ability to care for baby E.

5.6.4 In this case the assessment was not completed within the scope of the review.

LEARNING
The core assessment is an active process which at its best involves other agencies, so that all involved practitioners have an explicit chance to feed into assessment, analysis and consequent planning. Such involvement should assist in challenge as well as ensuring each agency provides full information. It is important that GPs are included in all such assessments.

5.7 BRUISING TO BABY E'S FACE

5.7.1 When the health visitor undertook a home visit and discovered baby E had bruising to the face she and her colleague appropriately identified the possibility of non accidental injury and the need for this to be reported to the social worker immediately.

5.7.2 The social worker and manager recognised the risk to baby E and the need for prompt assessment, providing an appropriate initial response by ensuring that baby E was seen by a duty social worker and a social work assistant, liaising with police to arrange a strategy discussion and arranging for baby E to be examined by a paediatrician.

5.7.3 However, the investigation process was weakened from the outset due to the lack of police involvement. This was a case of bruising to a vulnerable premature baby aged 11 weeks 4 days. The health visitor had doubts the explanation was consistent with the injuries. Moreover there was a history of concern in relation to both the adults in the home. This was a case that required an immediate s.47 enquiry and a joint investigation with the police because of the possibility of a criminal investigation.

5.7.4 4.6.6 describes the different perceptions of the managers involved, but the outcome of this liaison was that the police response was delayed for 2 hours, then without researching the history the officer declined police participation until the outcome of the paediatric examination was known and delayed undertaking the provision of 'checks' to C&F.

5.7.5 Even without researching the history, the presenting facts provided by the social work manager should have been sufficient to prompt police involvement in the paediatric examination so as to ensure that vital evidence was obtained, such as injury photographs.

LEARNING
Any suspicious injury to a non mobile baby / child need to be the subject of investigation, with police involvement from the outset so that potential forensic evidence is not lost or delayed

Diagnosis

5.7.6 Baby E was examined by a consultant paediatrician at the hospital. The paediatrician's considered that the bruising would require considerable sustained pressure which was improbable to have occurred as a result of rolling over against a belt. The paediatrician shared his concerns with the consultant on call and agreed the need to see the belt to conclusively state the injuries were non accidental.

5.7.7 The hospital individual management review comments that the written medical report did not 'quite reflect the level of concern for' baby E and the significance of facial bruising in an' eleven week ex-preterm non ambulant infant'. The individual management review author states that:

'Non-abusive bruising has a direct correlation to the developmental stage of the child under 5 years. Non ambulant children should not have bruises without a clear explanation.....Common and important sites for non accidental bruising include marks on face, scalp and ears'.

5.7.8 The report would have been more helpful to other agencies if it had clearly articulated the reasons for concern, the earlier social concerns when baby E was in the NNU and concluded with 'suspicious of non accidental injury' as opposed to 'it is less likely to be accidental injury'.

5.7.9 However, this was a report written in haste the next day because the social worker said it was not possible to progress the case without this. Whilst it is important to have a preliminary report quickly, this should not stop CSC from progressing the s.47 enquiry.

LEARNING
In order to effectively communicate to other agencies the wording of medical reports need to make the conclusions as clear as possible, and sum up all known risks.

Should there have been further medical investigation that day?

5.7.10 With hindsight, and the knowledge that subsequently baby E was diagnosed with injuries that were some weeks old, the question arises as whether further medical investigations should have been done at this presentation.

5.7.11 Given the history of concerns and the suspected non accidental bruising to the face a skeletal survey should have been performed at this hospital presentation. The police individual management review mentions police intention to obtain a skeletal survey to rule out previous injuries, but unfortunately this was not pursued. Had the police been involved

at this early stage it is possible they would have requested this at the time (along with photographs).

Inadequate consideration of risk in planning next stage

5.7.12 In the absence of the police view, the decision that night was for baby E to go home despite the paediatrician's view that this was 'less likely to be accidental injury'. Such decision making did not adequately factor the risks associated with a vulnerable premature baby, born at 28 weeks gestation, and at this point aged only 11 weeks old, presenting with unexplained bruising to the head. It was not known how the injuries occurred nor the identity of the perpetrator.

5.7.13 The paediatrician offered to examine child F, but this was never progressed. This would have been good practice.

5.7.14 The social worker consulted the manager and it was agreed baby E could go home with a written agreement that stipulated that Mr P should not undertake any childcare tasks. This agreement presupposes:

- That baby E's injuries were caused by Mr P and not by Mother
- That Mr P is only a risk if involved in unspecified 'childcare tasks'
- That mother could be relied on to be able to ensure Mr P kept to this agreement.

5.7.15 Given existing doubts about mother's abilities and the bonding with her baby all three of the above assumptions were flawed. Unfortunately the existence of this 'agreement' appears to have re-assured the social worker and the doctors on the day. The next day it was strengthened to exclude Mr. P from the household and from any contact with baby E and child F. However that was still reliant on mother's ability to implement such an arrangement and is based on the presumption that Mr P caused the injuries. See 6.7 for further discussion about written agreements.

5.7.16 The hospital management review sheds light on the thinking within the professional network at this point, with the perception of risk being Mr P's involvement in domestic violence. The doctor noted that baby E:

' was on a child in need plan because of the partner's history of domestic violence. Also notes that there were concerns about partner's children from previous relationship.'

5.7.17 The concern's about mother's possible learning difficulties and lack of bonding with her baby and possible lack of ability to protect her baby were somehow not perceived as potential risks for the welfare of her children, although it was recognised that mother had failed to obtain advice having noticed the bruising the previous day (according to her explanation).

LEARNING

When non accidental injury is suspected in a young child and the identity of the perpetrator is not known, the child should not usually be returned to the same home circumstances until investigations have been completed. In this case a return home should not have been considered until the belt was examined and a strategy meeting held to agree what further investigations were required.

When there is suspected non accidental injury of one child in the household the safety of all children in the household must be considered, including the use of paediatric assessment (as offered in this case). This is a learning point for other agencies.

Assessment: joint investigation

5.7.18 The joint investigation was characterised by delay, lack of leadership and lack of multi-agency approach.

5.7.19 Over the next 17 days there was little sign of progress in learning what had happened to baby E:

- It took 2 days to hold the strategy meeting
- There were no 'agency checks' and in particular the GP was not contacted – so the joint investigation were unaware of mother telling the GP she was 'tired all the time', 'wanting to run away' and not bonding with baby E
- The meeting included only police and CSC
- The planned photographs by the police were delayed until a week after the injuries occurred, and the bruises were no longer visible
- There is no evidence the police ever obtained the belt and the paediatricians did not see it as they requested
- The police individual management review refers to a discussion about a skeletal survey, but this was not undertaken
- There was a lack of feedback to the referring health visitor about the outcome of the paediatric examination and the GP was totally left out of the process and not invited to the planned follow up strategy meeting

5.7.20 The shortcomings in the investigations reduced the chances of discovering what had happened to baby E and the arrangements put in place to safeguard the children whilst the investigation proceeded were based on an assumption that firstly the mother was NOT the perpetrator and secondly she would be able to comply with a written agreement. Neither of these assumptions were based on reliable evidence. This is discussed further in 6.3.

LEARNING
In order to discover what happened to a child in a child protection enquiry and a police investigation it is imperative for the investigations to be multi-agency, to have strong ongoing and effective leadership and monitoring. Delay should not occur in the collection of forensic evidence.

5.8 BABY E'S ADMISSION TO HOSPITAL

5.8.1 The next opportunity for intervention arose when the health visitor returned to the family home. Once again the health visitor is to be commended for her intervention in identifying the risk presented by baby E's condition, mother's presentation and child F's comment heard by the nursery nurse regarding Mr P 'smacking' baby E.

Medical assessment: delays in NAI diagnosis

5.8.2 At hospital baby E presented on a Friday and was kept in over the week-end with a delay until Monday before non accidental injury was diagnosed. There were several reasons for this delay in diagnosis.

5.8.3 Firstly, Child F's comment had not been provided to the hospital: had it been so an earlier consideration of non accidental injury may have been considered. Critically neither the health visitor nor social worker mentioned this to hospital staff. Although baby E's notes were not available on admission, the history of being premature and previous concerns, including the current s.47 enquiry were known about, albeit the hospital were not kept informed of the progress of the investigation.

5.8.4 Secondly there was a delay and lack of urgency in undertaking further investigations.

5.8.5 It was noted that baby E's head circumference had risen from the 50th to the 91st centile between hospital presentations. The hospital management review points out that such crossing of several centiles in a child presenting with irritability and poor feeding points towards central / brain aetiology and given previous concerns should indicate the need for an early CT Brain Scan.

5.8.6 The management review author followed this up with the consultant who advised the paediatric registrar that Friday evening. They agreed to delay the scan as baby E was clinically stable and the 'radiology reporting would be of a better quality during the working week when a full complement of the team was available'. The author points out that from discussions with paediatric consultants at the Trust, management is based on clinical need regardless of the time of day or night, and that the concerns should have been discussed with the on-call radiology consultant.

5.8.7 The next day the nursing observations of baby E's irritability at the slightest movement might have resulted in an urgent scan had the consultant seen baby E during her ward round, but baby E was seen instead by an associate consultant who had not been previously involved.

5.8.8 An x-ray was arranged on the Saturday night due to baby E crying on being handled and having a 'tender' right thigh. The on call paediatric and orthopaedic registrars considered the possibility of a fracture, but rather than informing the consultant, decided to ask the day team to review, on the basis that baby E was in a safe place.

5.8.9 By the Sunday, the consultant on call was beginning to consider a fracture and discussed with Mother plans for a skeletal survey and CT scan, implying she was considering non-accidental injury as a strong possibility. However, this suspicion was not communicated to social care.

5.8.10 The orthopaedic team wanted to rule out any hip joint pathology, but the on-call radiology consultant was not trained in infant ultrasound scans. Finally on the Monday morning a right femur fracture was definitively confirmed by the orthopaedic and radiology consultants. Following this baby E had a skeletal survey, a CT head scan and an ophthalmological assessment.

LEARNING

- Practitioners need to understand that medical assessments do require knowledge of social concerns and in particular any concerns about suspected abuse: this may affect the medical investigations undertaken
- As soon as non accidental injury is suspected children's social care need to be informed so that consideration is given to the safety of the child in the hospital and any other siblings who remain at home. This applies to all cases but is critical when a child is already the subject of a s.47 enquiry as was known in this case
- For these reasons as well as the clinical care of the child, delays should not occur in diagnosis on the basis the child is safe in hospital
- Some of the delay was associated with both real and perceived limitations to expertise at the week-end: staff need to be aware of the source of out of hours expertise so that services are provided regardless of time of day or day of week
- This case highlights the need for consistency of review by the consultant on call, to ensure an overview is available.

Need to safeguard children

5.8.11 At the hospital on the Friday afternoon, the medical team were unaware of the allegation of Mr P smacking baby P. However, the health visitor had conveyed this to the social worker, which should have led to immediate communication with the police and consideration about any safeguards over the week-end.

5.8.12 Whilst baby E was thought to have been in a 'safe' place in the hospital, this does not deal with the potential risks arising from:

- The possibility that baby E could be discharged by her family
- Contact arrangements and potential need for supervision, especially as the perpetrator of the original bruising was not known and it the cause of baby E's ill health was at that point unknown
- Child F being at home with Mr P
- A written agreement that was unlikely to have been effective

5.8.13 Police were unaware of the hospital presentation and admission until they attended the previously arranged strategy meeting on the Monday to review the outcome of the investigations following baby E's bruised face. This meeting did make adequate arrangements for investigation and planning for the children's safety.

LEARNING

- When children are in hospital there is no legal basis for keeping them 'safe' should parents wish to discharge them – social workers and police need to agree with hospital staff contingency plans if the expectation is that the child must not return home
- Even when it is considered the child is safe in hospital, it is important that the need for police to be informed of any change of circumstances during a police investigation (at this point there remained an investigation into the bruising)
- It is vital that a s.47 is initiated whenever the threshold is met, as this clarifies concerns for all agencies and should facilitate better communication

6 CRITICAL ANALYSIS

6.1 INTRODUCTION

6.1.1 Chapter 5 looks at the critical points for decision making in this case and considers the assessments undertaken, including to what extent risk was recognised and plans implemented. In this chapter this analysis will be brought together under the specific terms of reference.

6.2 RISK FACTORS

6.2.1 One of the features of the practice in this case was that there was some good work undertaken in recognition and identification of risk, following the birth but having identified the risks there was a lack of decision making about *how* to assess the risks and *what* actions to take.

Risk from Mr P

6.2.2 From the birth of baby E there was a fast recognition that Mr P may be a risk and research done by police and by social care quickly established his history in relation to the Q family. This involved risks relating to domestic violence and to alleged physical abuse.

6.2.3 All agencies readily identified that domestic violence may be a risk to the children in this case. Despite such awareness, what was missing was the next step of assessing the significance of the risk to children, adjusting this with changed circumstances and undertaking new risk assessments with each incident (see 6.3).

6.2.4 Moreover the risk from Mr P seems to have been perceived largely as relating to the risk of domestic violence, with little focus on the historic allegations made by Ms Q's children, as another potential risk.

Maternal capacity risks

6.2.5 The risk factors relating to mother prior to the birth were not identified and possibly not known about by the midwife (see 5.2), but after the birth it was identified from the outset that there were possible issues relating to learning difficulties and to her bonding with her baby. However, this did not lead to further assessments or the consideration of the implications of such issues for the safety and development of the children.

Unrecognised risks

6.2.6 Research shows that premature babies are more at risk of abuse.[11] The fact that Mother had a history of poor bonding was particularly significant, as premature babies need more parental effort to develop attachment, and from this perspective the mother's poor bonding can be identified as a risk to baby E's development, and also as possibly lowering Mother's protective urges. The management reviews did not provide evidence that this additional vulnerability of baby E was factored into risk assessments once baby E was ready for discharge from hospital.

[11] Eileen Munro: Effective Child Protection; 2008; Page 65

6.2.7 Generally risk was acknowledged by social care in relation to concerns previously identified with Mr P or identified about mother by the hospital and the police. What was missed was the risk implied by information that went directly to social workers:

- The various allegations made by mother about father's behaviour, which if true would have indicated risk
- The allegation that baby E's birth followed a fight at home

6.2.8 This last allegation was extremely significant but there is no evidence it was shared with any other agency.

6.2.9 The police did not immediately grasp the significance of bruising to such a young baby and did not initially respond with the appropriate level of priority.

LEARNING
The identification of risks is the first part of assessment processes. This needs to be followed by consideration of the implications for the children of such a risk, how to evaluate the extent of the risk and the possibility of being able to minimise it.

6.3 ASSESSMENTS

6.3.1 Chapter 5 describes the quality of the various assessments that were undertaken in the agencies as a result of specific incidents that provided an opportunity to intervene. A number of multi-agency themes issues arise from some of these assessments:

- Avoidance of child protection threshold
- Joint investigative practice
- Lack of specific assessments to understand the quality and ability of the carers
- Analytical and intuitive reasoning

Avoidance of child protection threshold

6.3.2 As discussed in 5.4, there were grounds to convene a strategy meeting after the birth of baby E due to the identified risks (even ignoring the allegation that a fight led to the birth of baby E). Mr P's presence within the home in itself should have been enough to trigger such a discussion given that children in the Q family, including his own child, were subject to child protection plans in part due to the risks identified by his contact with the family. It is indicated within the C&F management review that the reluctance was in part due to having no new evidence of concerns about Mr P in relation to the new household.

6.3.3 Further opportunities arose for holding strategy discussions due to the identified concerns about mother's parenting abilities and lack of bonding with her baby.

6.3.4 C&F was not alone in avoiding recognition of the child protection threshold. The police delayed in getting involved when baby E had bruising to the face and the paediatricians on the last week-end delayed when the fracture was suspected but not confirmed.

6.3.5 Implicit in the practice demonstrated in this case is a search for 'evidence' prior to deciding if this is child protection. In the authors experience this is not unusual. Since 1995 and the publication of *Messages from Research*[12] there has been reluctance to pick up too many cases into the child protection arena:

[12] Child Protection : Messages from Research DOH 1995

'This research led to a shift in thinking at the Department of Health. All child care referrals were to be responded to as inquiries about the needs of children, rather than as child protection investigations. Cases were to be considered as child protection when there was serious abuse or neglect that was likely to continue and to have long term adverse consequences. More families were to be offered family support measures, particularly those who had not been deemed as being sufficiently high risk (i.e. they had not crossed the 'threshold' into child protection) (Corby 2003').[13]

6.3.6 However, in the absence of the investigative response associated with a s.47 enquiry, the assessments undertaken did not provide the more forensic examination of the concerns so as to be able to understand the risks to the children.

6.3.7 S.47 of the Children Act 1989 states that the authority *'shall make, or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard or promote the child's welfare'* when they *'have reasonable cause to suspect that a child who lives, or is found, in their area is suffering, or is likely to suffer, significant harm'*.

6.3.8 The law does *not* say there needs to be evidence; the s.47 enquiry and police investigation role is to provide that evidence. The use of a strategy discussion or meeting is at an even lower threshold level, as this is how the decision is made to initiate such enquiries.

LEARNING
S. 47 enquiries should be initiated in accordance with the law, when there is suspicion (as opposed to evidence) that a child is suffering or likely to suffer significant harm – the strategy discussion or meeting is held to discover if there is such suspicion.
Such suspicion takes account of historical concerns as well as new ones.

Joint investigative practice

6.3.9 There was only one s.47 enquiry and allied criminal investigation in the period under review. As described in 5.7.18-21 the basic process was not followed and other than one joint visit there was insufficient 'jointness' about the investigation.

6.3.10 Initially the police declined to be involved, and then there was a delay in the strategy meeting and an absence of working together with other agencies. Whilst the police did undertake interviews of mother and Mr P, the investigation did not adequately follow up:

- The evidential aspects of photographs (delayed)
- Examination of the belt
- A possible skeletal survey
- Paediatric examination of the sibling and
- The allegations made by a member of the public

6.3.11 There were neither agency checks nor feedback to other agencies, albeit a review strategy meeting had been planned to do the latter. However, the GP had not been invited and was not informed of the concerns.

6.3.12 What is not clear from this one example is the extent to which this may be a systemic problem, or one of individual training needs

[13] Corby (2003) quoted in *Safeguarding in the 21st century – where to now* Jane Barlow with Jane Scott 2010

LEARNING
Police and social care need to discover whether the joint investigative practice in this case is usual or an anomaly.

Analytical and intuitive reasoning

6.3.13 Eileen Munro[14] refers to the relative roles of 'intuitive' and 'analytical' thinking in social work. She describes the current 'drive for more explicit, critical, evidence-based practice' and that within analytical reasoning, emotion has been viewed mainly in a negative light. Munro argues the need to combine analytical and intuitive thinking, so that we pay attention to our emotions and our 'gut' feelings.

6.3.14 In this case the social care management review mentions that both social worker and team manager had 'gut feelings' about Mr P. The social worker 'explained that the reason she made an unusual number of unannounced visits was because she was not confident that Mother would follow advice to prevent Mr P having sole care of either child, as he would be the partner 'in control'. The social worker's encounters with Mr P increased her 'uneasy' feelings due to his 'false indications of closeness/understanding of child F.

6.3.15 Despite this growing uneasiness (and the identified risk factors) social workers did not judge that the child protection threshold had been reached. They were unsuccessful in being able to use their intuition to develop thinking about the case; to identify the source of such emotions and the significance of these for risks to children.

LEARNING
Social workers and their managers need to develop skills in being able to combine analytical and emotional thinking, when assessing the care of children and in particular the risks to them. Reflective supervision and/or mentoring should assist front line staff to make use of such emotions in their work.

6.4 PARENTING CAPACITY

6.4.1 One of the major weaknesses of the assessments undertaken was the lack of understanding provided with regard to the parenting capacity in this family. There was no assessment whatsoever of father and only one telephone contact by the social worker. This is discussed below (see 6. 5).

6.4.2 Although Mr P was known to be living in the family home for most of the period under review, there was no assessment of his capacity as a carer, as the work with the family was on a basis that he was a risk and not to be involved in parenting. However, this was unrealistic as he continued to be involved with the family throughout the period.

Assessment of Maternal capacity

[14] Eileen Munro, Effective Child Protection 2008 Sage Publications

6.4.3 Having identified that Mr P was a risk, all responsibility was placed on Mother to protect her children without any realistic assessment of her capacity to either parent the children herself, without his help, or to be able to prevent his access to the children.

6.4.4 Following the premature birth of baby E there were immediate concerns about maternal learning difficulties and her ability to care for the baby. This was raised by the police officer who saw Mother after the birth on the ward, was part of the social worker's initial assessment, mentioned in the discharge planning meeting in terms of Mother's limited understanding of her baby's needs and raised by health practitioners following baby E's discharge at age 9 weeks, having observed her difficulty in comprehending advice.

6.4.5 Moreover, one of the constant themes in the 14 weeks following baby E's birth was Mother's observed lack of bonding with her child, from the early days when she did not visit the baby consistently in the neo natal unit, to her observed responses when handling her baby and finally to her own expressed doubts to the GP and health visitor about her feelings to baby E.

6.4.6 Whilst in hospital there were concerns around the lack of bonding between Mother and baby, with Mother spending insufficient time with her baby and not seeking to be involved in basic tasks such as feeding or demonstrating an understanding of the baby's needs.

6.4.7 However, following the discharge meeting when baby E was aged 6 weeks, with Mother placed under pressure to visit her baby, she became more actively involved with baby E albeit she still did not achieve consistent daily visits to the hospital. On the basis of such improvement baby E was able to be discharged home without any further understanding of why Mother showed unusually little interest in her baby.

6.4.8 Baby E may have been at greater risk of attachment problems by then due to the long period in the neonatal unit with inconsistent visits from the Mother and with Father prevented from visiting (see 6.2). The observations of Mother's parenting subsequently would have indicated continuing risk of this. Cleaver et al[15] cite Fahlberg's [16] work in 1991 showing that 'babies and infants who are regularly rejected come to see themselves as unloved and unlovable'. Also quoted is recent research by Egeland[17] 'that by the age of 12 months 'half the infants whose cries and pleas for warmth and comforting were ignored were anxiously attached and by 18 months of age this applied to all the infants'.

6.4.9 From the point of baby E's move to the family home, the concerns about Mother's ability to provide adequate care of her premature baby continued: Mother did not maintain a feeding chart as requested, appeared not to understand or follow advice e.g. not obtaining repeat medication for baby E and needing reminding to feed her baby.

6.4.10 Although baby E continued to gain weight when discharged from hospital, these observations of Mother with her baby were of significant concern as they would have a likely impact on the developing relationship between Mother and child and the quality of the child's attachments. Most critically Mother expressed to the GP that she was tired all the time, wanting to run away and not bonding with baby E and the health visitor commented

[15] Cleaver, H, Unell I and Aldgate J (2011) Children's Needs – Parenting Capacity, TSO
[16] Fahlberg, V I (1991) A Child's Journey through Placement BAAF, London
[17] Egeland , B (2009) Taking Stock, Childhood emotional maltreatment and developmental psychopathology' Child Abuse & Neglect 33, 1, 22-27

in interview that she had noticed that baby E did not respond to Mother when handled and sensed that Mother and baby were unusually detached from each other.

6.4.11 Despite this identification of concerns about Mother's possible learning difficulties and lack of response to her baby, at no time was there an adequate attempt to assess the cause and likely outcomes of the observed problems and in particular:

- Whether Mother was suffering from any mental health issues?
- Whether Mother had learning difficulties?
- The impact of such issues upon her parenting capacity?
- What this would mean for the care of a premature baby and what help and support was indicated as a consequence

6.4.12 Such a thorough assessment would be best undertaken explicitly as early as possible. It is very worrying that despite the early concerns:

- After 14 weeks in hospital practitioners working with the family had no further understanding of the cause of Mother's difficulties in interacting with her baby and providing consistent care than they had at baby E's birth
- About possible learning difficulties, there is no evidence any further research or assessment undertaken within the period under review, such as obtaining information from Mother's school records or consultation with experts.

LEARNING

It is vital that potential issues relating to parenting capacity such as depression, low self esteem and learning difficulties, are identified and evaluated as early as possible. In this instance such risks were raised, but never fully explored and assessed.

6.5 RESPONSE TO MEN

6.5.1 One of the findings of the biennial reviews into serious case reviews about fathers and men is:

'... the dearth of information about men in most serious case reviews; failure to take fathers and other men connected to the families into account in assessments; rigid thinking about father figures as all good or all bad; and the perceived threat posed by men to workers.[18]

6.5.2 This was certainly a feature of practice in this case, with the lack of engagement with father by professionals, especially social workers.

6.5.3 Father should have been involved from the outset due to the concerns that were being expressed about his children arising from Mother's relationship with Mr P. Parents have a right to know about such concerns and should be involved by social workers in discussions about how to keep them safe. Moreover any assessments, initial or core, of children need to involve all significant members of the child's world, and certainly directly involve all carers and wherever possible both parents.

6.5.4 Also from the outset mother was making allegations about Father in terms of domestic violence and slapping child F. It is not clear why there was no follow up to these comments, except maybe due to social workers believing mother's accounts that he was not interested

[18] Understanding Serious Case Reviews and their Impact A Biennial Analysis of Serious Case Reviews 2005-07 (DCSF 2009) Brandon et al

or involved with child F and she did not want him to have contact. Given his observed relationship with baby E at hospital such an explanation does not seem to be credible.

6.5.5 The decision at the hospital discharge meeting to exclude father from both the meeting and the contact with baby E was wrong, both in terms of the law and in consideration of the child's welfare.

6.5.6 This decision came about due to Mother claiming not to visit her baby regularly due to fear of encountering the Father. This was in itself not credible as she had previously given a variety of alternative explanations which needed challenging, so as to get closer to the truth about her lack of involvement with baby E. Moreover, arrangements could have been made to ensure the parents did not meet when visiting.

6.5.7 Some participants at the meeting understood that they had the power to prevent Father's visits due to his not having parental responsibility; whether Father did or did not have parental responsibility this would not have provided a legal or a moral basis for such action. The C&F IMR author has established though that the social workers were not under this misapprehension and it remains puzzling why they thought this action was reasonable.

6.5.8 Most significantly of all, up to that point there was concern about Mother's lack of interest and bonding with her baby. In contrast Father was observed to cuddle his child and ask questions about baby E's health and development. Depriving baby E of the Father's contact risked depriving baby E of that all important early bonding with parents.

6.5.9 The decision was communicated to Father by telephone and was the only identified contact between him and a social worker during the entire period under review, despite the concerns about the children's care and the bruising to baby E which led to the s.47 enquiry.

Men and domestic violence

6.5.10 As discussed in 6.2 practitioners now have no difficulty identifying risks to children from domestic violence, and this evidences the positive achievement of training programmes in recent years.

6.5.11 However, with this has come the unintended consequence of stereotypical thinking about domestic abuse and the perpetrators, which seems to re-inforce the tendency to exclude men from households, and from assessments, without a full understanding of the relationship dynamics, and even more significantly the realistic chances that such theoretical exclusion from a household will actually take place.

6.5.12 In this case Mother's allegations against Father seem to have been accepted at face value. Without any attempt to establish the exact nature of the allegations by mother, or the truth about these, and without giving father the opportunity to even know what was being alleged, father was excluded from assessments and from having contact with his own baby.

6.5.13 The knowledge of Mr P's relationship with Ms Q and her children led into the assumptions made that he was the perpetrator of the bruising to baby E so to exclude him from the household would ensure baby E's safety. Again this was prior to any investigation as to the perpetrator of the injuries.

6.5.14 Such assumptions reflect the stereotypical domestic violence relationship and to the extent that this is part of the culture of agencies will impact on the approach taken by staff to family members.

6.5.15 Dutton & Nicholls[19] describe how such thinking contributes to the persistence of belief in the male always being the aggressor and that

'Kahneman et al. described the tendency of humans to make premature causal judgments, often based on unconscious biases in human inference. Personal experience is an especially erroneous basis for making social judgment as we tend to give too much weight to single, salient experiences and to subsequently discount contrary data to the "confirmatory bias" we have established. Lord et al. illustrated how contradictory data sets are systemically discounted. Janis (1982) further demonstrated how social groups evolve a social reality called "groupthink" where group ideology is protected by and serves to self-sustain through rationalizations for discounting contradictory data. A conjunction of the social psychological phenomena of groupthink and belief perseverance appears to account for the "paradigm" (or "worldview") and ensuing urban myth surrounding domestic violence...'

LEARNING

All agencies need to develop a culture that involves both parents in terms of assessments and concerns, without making stereotypical assumptions about the men based on allegations of domestic violence.

In most circumstances this requires both parents to have knowledge of concerns about their children's care, whether they are living with them or not. It also means that allegations also need to be followed up, regardless of which parent has care of the children.

This should be the usual practice with any decision to exclude a particular parent being explicitly recorded, with its rationale.

Practitioners and managers need to be mindful of this and challenge each other when a parent is being excluded.

6.6 FOCUS ON THE CHILD

6.6.1 In the emergency situations that occurred in this case the officers at the scene had some problems maintaining a focus on the child as is illustrated when police were dealing with domestic violence issues in the Q family and took 25 minutes to check on the children left alone at the house.

6.6.2 On the day of baby E's birth, it took police 30 minutes to be aware of child F's presence in the home, when family members came to collect the child. This is partly explained by the fact that the police had not entered the address and the focus was on getting Mother and baby to hospital. Neither ambulance staff nor Mr P mentioned the child's presence. The officers did not record Mother's agreement for her elder child to be taken by family members, nor was the decision discussed with the local authority OOH team.

6.6.3 Most critically of all the police officers did not take details and contact numbers of family members so as to be able to know where child F was taken, or to be able to undertake checks if required. They were perhaps re-assured by MGM's assertion that she often looked after child F. However, this meant that C&F would not have had the details available to locate child F and ensure child F's welfare.

[19] The Gender Paradigm In Domestic Violence: Research And Theory (Donald G. Dutton and Tonia L. Nicholls)

LEARNING
When staff respond to emergencies, they may forget to consider the tasks involved relating to children not involved in the emergency. There is a need for a 'think children' approach to be embedded within the culture of the police with systemic safeguards to remind the officers dealing with unexpected and / or immediate crisis.

6.6.4 The social workers, midwives, community nurses, health visitors and nursery nurse all paid attention to both children in the household and the health visitor was particularly alert to non verbal cues of the parent/child interaction indicating attachment problems.

6.6.5 The hospital paediatrician who examined baby E for the facial bruising did consider child F offering to examine the sibling.

6.6.6 However, despite the attention paid to child F when present, there was little focus on this sibling. Little was known of the sibling's care when baby E was in hospital, little was learnt about the reason for the neglect issues mentioned by the nursery school. Most worrying was that when baby E was admitted to hospital there is no evidence that any of the staff involved in any agency considered the sibling's care during the week-end when mother was at the hospital.

LEARNING
When responding to emergencies about one child practitioners in all agencies need to consider the implications for any siblings.

6.7 IMPLEMENTATION OF PLANS & USE OF WRITTEN AGREEMENTS

6.7.1 Despite the children having been identified as children in need they were not subject to a child in need plan during the period under review. The only plan to emerge from the initial assessment was to transfer the case for a core assessment. No plans were made for support or specific assessments, other than a core assessment.

6.7.2 The discharge meeting did agree a plan of support by health staff and social care which was implemented by professionals, but the family did not keep to the agreement: Mother did not visit daily nor for extended periods and MGM stayed for only a couple of days instead of a couple of weeks.

6.7.3 The main part of the planning was around verbal and then written agreements with Mother regarding Mr. P's role in the household. These specified variously that Mr P should not be involved in any childcare tasks, then that he should not have any form of contact with the children and not remain living in the house.

6.7.4 The latter agreement was imposed after the bruising was discovered, but the chance of it being successfully monitored was diminished by the fact that it was not subsequently shared with other agencies.

6.7.5 If there was any doubt before, it became clear that mother could not be trusted to keep to the agreement during the joint investigation as:

- She made her feeling clear to the police that she would have Mr P home even if he was found to have caused the injuries
- Mr P called the social worker from the flat on one occasion
- When the social worker visited another time, Mr P was outside the flat
- Mother spoke about her intention to move to London with Mr P
- In addition Mr P had shown no respect for written agreements when in family Q

LEARNING
When plans are made with families, there needs to be specific attention given to explicit contingency arrangements, which are them implemented if there is non-compliance.
The use of written agreements is useful in so much as it makes expectations clear to all parties, and is helpful in any subsequent legal proceedings. However, without contingency arrangements and stringent multi-agency monitoring they are of limited use, and can give a false sense of re-assurance to staff.

6.8 DIVERSITY

6.8.1 Mother and her new partner are White British, and the children's Father is a British Asian. Whilst there is no evidence that the ethnic or cultural issues affected the service provided to the family, it is not known how the father felt about the service he received and whether he perceived any issues relating to his race.

6.8.2 It is also not known without discussion with the family if there were any cultural issues that affected the breakdown of the parental relationship or the subsequent pretence by mother that the father was disinterested in his children. Most critically Mother reported difficulty relating to her children as they reminded her of their father. This may have explained some or all of mother's difficulties in bonding with baby E. It would also have been a potential problem as the children grew older in relation to their identity.

6.9 POLICY CONTEXT AND COMPLIANCE

6.9.1 Midwifery, GP, health visiting and neonatal care were all delivered in line with local policies and procedures.

6.9.2 Within the hospital there were three aspects of clinical practice that were not complaint with national or local procedures and guidance:

- The lack of skeletal survey when baby E presented with facial bruising
- The gaps in clinical documentation
- The delay in informing social care of the suspected femur fracture

6.9.3 The police have identified through this review that there was a recurrent incidence of inappropriate crime recording. In the field of domestic abuse, this relates to incidents remaining 'non crimes' when there was evidence of a crime and that the National Police Improvement Agency 2008 Guidance on Investigating Domestic Abuse specifically states that '*Failure to make an arrest when there are grounds to do so may leave a victim at risk from further offences*'.

6.9.4 The police found also that this applied in the responses to alleged assaults within the Q family, when a crime recording decision should have been made on the first contact in one instance. On another occasion the officers decided against arranging a medical examination of a young child who alleged assault on the basis that the disclosure was unclear and the injury minor. The local protocol advises that a consultant paediatrician should have been contacted and an examination advised.

6.9.5 The joint investigative practice was not compliant with national guidance and local procedures. In particular the following parts of Buckinghamshire's procedures were not followed:

***14.5** : 'The discussion must generally involve, at a minimum, both Children's Social Care and the Police CAIU with other agencies included as appropriate, in particular the referring agency, the child's nursery/school, health and (where relevant) the registered owner of service and registration authority'*
***14.13:** 'Meetings should be held at a convenient location and time for the key attendees e.g. Children's Social Care office, police station, hospital, GP surgery or school'*
***14.21**'Timing of subsequent discussions' 'All enquiries should have a final discussion to agree outcomes and in general, this should not delay an initial conference being held within 15 days of the initial strategy discussion. Some enquiries will be more complicated and may require several review strategy discussions, which should be held at intervals not exceeding 15 working days'*
***14.22**: 'In all cases, if required, any initial child protection conference must take place within 15 working days of the final strategy discussion'.*

6.10 INFORMATION SHARING & COMMUNICATION

6.10.1 Information sharing practice was inconsistent within and between agencies, with some good examples of practice and some particular significant omissions.

GP working in isolation

6.10.2 The most glaring and consistent omission was with the GP who was excluded from most of the communications within health. The GP was not informed of:

- Mother's discharge from hospital
- The concerns about baby E, except for a written and delayed hospital discharge summary which provided no explanation of 'social problems'

6.10.3 As a consequence the GP saw Mother on 2 occasions without an understanding of the social concerns that other health colleagues knew about and without recent medical history. Consequently the GP was reliant on Mother's version of events and the assessment was limited to clinical presentation on the day. The first of these assessments was further limited as Mother was a new patient and the GP had not yet got access to the medical records.

6.10.4 Not only was the GP not receiving communications from the health agencies, but s/he was not contacted as part of the s.47 enquiry to provide history, because the social worker (mistakenly) thought this was a health visitor responsibility. This meant that the s.47 enquiry was unaware that Mother has been to the GP complaining of feeling tired and not bonding with baby E. If that had been discovered, it is likely that alternative safeguarding arrangements would have followed the discovery of bruising.

LEARNING
There needs to be clarification about what should be shared and who is responsible for sharing information with the GP, both within the health service and with C&F.

Pre-birth

6.10.5 It is of concern that the community midwife had no information of any social issues / concerns from the parenting of child F, despite the health visitor having pertinent information which may have helped identify mother's vulnerabilities. This reflects systemic issues, as opposed to individual error.

Between Out of Hours and the Police

6.10.6 When police contacted the Out of Hours social care service in the night they were provided with information, but some was wrong (that Mr P's child was a child in need not subject to a protection plan). There are systemic issues that make accessing information on ICS complex (see 6.14)

6.10.7 The difficulties in communication between the 2 services arose partly due to lack of clarity about the reason for the contact, and whether this was for information or a referral, with the police not realising that social care have this distinction. In fact this is often a mute point as the determining factor, as in this case, was dependent on the result of the information.

6.10.8 More importantly is the need for communication to take place between experienced staff able to consider and agree 'out of hours safeguarding management plans'.

When baby E was in NNU

6.10.9 When baby E was in hospital there was good communication between the hospital staff, the social worker, the community liaison nursing team, the named nurse for child protection and the health visiting team. However, the community midwife was not informed of the concerns about Mr P and an opportunity was lost to obtain information about mother and her new partner at home and his involvement or not with child F. The health overview author is uncertain if this lapse in communication is systemic or the result of mothers earlier discharge from hospital without her baby.

6.10.10 It was unfortunate that at a critical point in this case information sharing with the GP and health visitors was disrupted by a relocation of the health visitors and the introduction of an electronic notes system.

When baby E suffered facial bruising

6.10.11 The lack of checks undertaken as part of the s.47 enquiry meant that there was an opportunity lost for information sharing.

When baby E was in hospital over the week-end

6.10.12 One of the most critical lapses in information sharing was the knowledge held by the health visitor and communicated to the social worker of the allegation by child F that Mr P had smacked baby E. It is not clear why this was not communicated to the hospital, nor why it didn't in itself lead to information sharing with police and consideration of the safety of child F over the week-end. However, if the paediatricians had been aware of this it may have led to consideration of child F once a fracture was suspected during the week-end and the need to inform C&F.

6.10.13 Had there been a strategy discussion / meeting immediately this information would have been communicated

LEARNING

The social worker acknowledged as part of the review the difficulties in keeping everyone updated, especially as it may take more than one attempt to speak to them. Whilst this is no doubt true, there need to be systems put in place to enable such updates (e.g. emails to all involved agencies) and other agencies should also take responsibility for ensuring they are have received updates.

6.11 MULTI-AGENCY WORKING

6.11.1 Because the work undertaken on this case was not under the auspices of a child in need plan or a child protection plan there was an absence of a co-ordinated team around the child working together to implement a plan and to meet regularly to review progress.

6.11.2 In the weeks following baby E's birth there was very good multi-agency working between hospital staff, C&F and police, except that the police's initial suggestion of a strategy meeting was not taken up by C&F. That was a misjudgement.

6.11.3 The hospital discharge meeting demonstrated good practice, albeit that its remit was narrower than a child in need meeting would have been, essentially focusing on discharge planning, at a time when a more holistic meeting was needed.

Joint investigative practice

6.11.4 There were though some particular difficult areas in the working together arrangements between police and C&F which affected the ability to intervene more effectively in investigating the bruising.

6.11.5 The social work managers both (as part of this review) expressed their concerns about the reluctance from the police to accept the seriousness of concerns until the paediatricians confirmed the 'evidence' of non accidental injury. What is of particular concern in these interviews was the perception of changes in joint investigative practice which affect this early exchange of information and which have resulted in delays in police taking part in investigations in this case and others.

6.11.6 Moreover in this case it took 2 days to reach agreement to hold a strategy meeting, but unfortunately this was limited to police and C&F participation. The absence of other agencies, and particularly the paediatrician, was significant on this occasion. Had they been included it may have led to a higher priority being put to the investigative tasks so timely photographs could have been taken and the belt examined.

Core assessment

6.11.7 Within C&F there is a lack of available guidance about core assessment practice and a belief that whilst using information from other agencies, no multi-agency meeting is held to analyse the information, so the first meeting is when the plan is completed and meetings are then held to monitor its implementation. This never happened because the core assessment was not finalised during the period under review.

6.11.8 The assessments undertaken by C&F were considerably weakened by the absence of GP information and the lack of multi-agency expertise to contribute to the core assessment.

Written agreements

6.11.9 The ability of the multi-agency network to monitor the safeguards put in place via the written agreements were undermined due to the lack of knowledge of some health staff of the outcomes of the referrals to C&F and of the content (or even existence) of the written agreement.

LEARNING
The new Working Together in 2013 will provide the opportunity for the LSCB to agree new arrangements for multi-agency collaboration in assessments and in child protection enquiries, and develop a culture that is more collaborative
There is a need to establish if the changes to joint investigation highlighted in this case are unusual or reflect some underlying practice changes within police and C&F. There is no up to date joint protocol, so this will be a good opportunity to develop such local agreements.

6.12 KNOWLEDGE AND EXPERIENCE OF STAFF/PROFESSIONALS

6.12.1 The extensive knowledge and experience of the health visitor was a significant factor in baby E receiving timely medical interventions and for the recognition of the need for child protection intervention. Her work on this case is commendable and possibly prevented baby E from suffering further harm.

6.12.2 All staff in this case within health had access to child protection training and ongoing professional development opportunities. The GP, Midwives and members of the health visiting team were all up to date with training requirements. Within the hospital the position is not so clear so the IMR has recommended a training needs analysis to identify the needs of paediatric medical staff.

6.12.3 Within C&F all the staff were appropriately qualified and trained in child protection. The managers though having received corporate management training felt that this did not provide sufficient relevance to the needs of social work management and particularly the ability to use reflective practice.

LEARNING
Social work managers need the training to equip them to provide the reflective supervision for their staff.

6.12.4 The police management review reflects on the need for discussions with Out of Hours social care to involve supervisory police officers when there are child protection issues that require decisions being made as opposed to just transfer of information. This is covered in the management review recommendations.

6.12.5 The misclassification of the DASH forms has highlighted the lack of recent training for TVP PCs since the forms were introduced in 2009 on classifications and the responsibility of attending Officers. This is now being incorporated into the agenda of domestic abuse 'Master class' being delivered across the service, so is not covered in the recommendations.

6.13 MANAGEMENT AND SUPERVISION

6.13.1 Within C&F there was evidence of management involvement and direction throughout this case, and in particular during the period of the child protection enquiry. In the absence of the allocated workers there was also good cover from duty officers and duty team manager.

6.13.2 The TVP have already recognised the sporadic and varied supervision of the DASH risk assessment process and the ongoing pilot project has picked up the issues that arose in this case, including the provision of scanners at remote stations so that the form can be scanned and emailed to a supervisor prior to forwarding to the Referral Centre.

6.13.3 Within health all staff have access to designated and/or named safeguarding professionals, and they were involved in this case providing advice to the health visitor and nursing staff in the hospital. The named doctor's advice was not accessed and within the Trust the designated and named doctors are in the process of developing more robust supervision arrangements for medical colleagues involved in challenging child protection cases.

6.14 ORGANISATIONAL ISSUES

6.14.1 The C&F management review explains that the Integrated Children's System workflow is prescriptive and unintentionally has dictated practice, rather than being a 'tool' to record the practice. In the context of this case, it has led to a linear work flow which the author judges discourages a move into the child protection threshold once a child in need approach has been followed. If this is the case, it would be extremely worrying and need urgent attention.

6.14.2 It is also problematic for out of hours staff to easily access information, as it does not provide summaries or useful chronologies.

6.14.3 The adult individual records are also not helpful as they omit crucial information that will be on the children's files and hence would require location and examination of every child's file with whom a particular adult has been associated. In the case of men who have had many partners, this would be a massive task.

LEARNING

The introduction of ICS has caused considerable upheaval and has had unintentional consequences in terms of both accessibility of information and potential disincentives to move a case into the child protection arena. There is urgent need for further research to identify the problems and consider how this 'tool' can be more user friendly and also serve practice as opposed to imposing limitations.

Further review needs to be undertaken of the contents of adult records so that staff are easily able to access pertinent information, especially relating to an individual's history and any risks to children.

6.15 CAPACITY

6.15.1 There were no specific capacity issues that had an impact on this case, although the Out of Hours service has identified the need for additional resources including staff with C&F experience.

7 CONCLUSIONS

7.1 INTRODUCTION

7.1.1 Baby E was a premature baby and the emergency services and the hospital Neo Natal Unit are to be commended for their fast responses and the support provided to the family, albeit there were some learning about communication and the need to consider all children in a family.

7.1.2 From the start there was overall good research undertaken of the history known by each agency, albeit the Out of Hours Service of the Local Authority faced problems due to the complexity of searching for information about adults on the children's electronic care record.

7.1.3 However having recognised risks to the children in the household, there was a reluctance to identify these in terms of the child protection threshold, with the view that further evidence was required to be able to explicitly consider this further.

7.1.4 The assessments undertaken in response to these concerns followed usual assessment processes, but did not sufficiently address parenting capacity issues so that judgments may be made about the cause of the problems, the potential for change and the likely outcomes for the child.

7.1.5 The health visitor is to be commended for her interventions, identifying risk, alerting social care and facilitating baby E's presentation at the hospital.

7.1.6 When the child protection threshold was identified, the subsequent multi-agency investigative process (medical, police and social care) lacked rigour, consequently weakening the chances of identifying the perpetrator of the bruising on baby E and potentially the extent of baby E's injuries.

7.1.7 Having identified the child protection threshold, assumptions were made about the identity of the perpetrator and the ability of the mother to safeguard her children, so leaving both children at risk of significant harm in the home. There was no evidence to support either of these assumptions.

7.1.8 Multi-agency processes were insufficiently collaborative; this weakened the assessments undertaken. Most strikingly the GP was totally excluded from all such processes as well as routine communications, which impacted on available information about the relationship between mother and her baby.

7.1.9 The birth father was ignored in this case. He was not informed about the concerns for his children, nor of allegations made against him. Moreover his exclusion from contact with his baby was not consistent with the welfare of baby E nor was it consistent with the law.

7.2 LESSONS LEARNT

Assessment

7.2.1 The identification of risks is the first part of assessment processes. This needs to be followed by consideration of the implications for the children of such a risk, how to evaluate the extent of the risk and the possibility of being able to minimise it.

7.2.2 Potential issues relating to parenting capacity such as depression, low self esteem and learning difficulties need to be identified and explicitly evaluated as early as possible. In this instance such risks were raised, but not fully explored and assessed.

7.2.3 There is a need to ensure that TVP staff undertaking domestic abuse risk assessment work understand the need:

- To ensure that any assessment takes full account of history of household members, both in relation to domestic abuse and child protection
- To raise the risk level in circumstances when the victim is not engaging
- For a new risk assessment for every incident regardless of the content of the allegations or the date of the previous incident

Joint investigation practice

7.2.4 S. 47 enquiries should be initiated in accordance with the law, when there is suspicion (as opposed to evidence) that a child is suffering or likely to suffer significant harm – the strategy discussion or meeting is held to discover if there is such suspicion. It is vital that a s.47 is initiated whenever this threshold is met, as this clarifies concerns for all agencies. There is an urgent need to discover if there are systemic problems within the multi-agency system that inhibited social workers, paediatricians and the police from recognising this threshold at various points with baby E.

7.2.5 Any suspicious injury to a non mobile baby / child must be the subject of investigation, with police involvement from the outset so that potential forensic evidence is not lost or delayed. The police have had recent training input on this, so no recommendation has been made.

7.2.6 In order for s.47 enquiries and associated criminal investigations to succeed in discovering what happened to a child, it is imperative the investigations are multi-agency co-ordinated and monitored by timely strategy discussions / meetings. Delay should not occur in the collection of forensic evidence and allegations need to be followed up before witnesses reconsider their position.

7.2.7 When non accidental injury is suspected in a young child and the identity of the perpetrator is unknown, the child should not usually be returned to the same home circumstances until investigations have been completed. In this case a return home should not have been considered until a strategy meeting was held to agree what further investigations were required.

7.2.8 When there is suspected non accidental injury of one child in the household the safety of all children in the household need to be considered, including the use of paediatric assessment (as offered in this case).

7.2.9 When children are in hospital there is no legal basis for keeping them 'safe' should parents wish to discharge them – social workers and police need to agree with hospital staff contingency plans if the expectation is that the child must not be discharged

7.2.10 Even when it is considered the child is safe in hospital, it is important that police are informed of any change of circumstances during a police investigation, such as further allegations / child admitted to hospital.

7.2.11 The weaknesses in joint practice may be associated with the lapsed use of the joint investigation protocol and this is a timely reminder of the need for such local agreements.

Health assessments

7.2.12 Pre-birth assessments to consider the need for health visiting support prior to the birth, need to be holistic and take account information from all sources, not just the midwives identification of maternal vulnerability.

Paediatric assessments

7.2.13 In order to effectively communicate to other agencies, the wording of medical reports need to make the conclusions as clear as possible, and sum up all known risks.

7.2.14 As soon as non accidental injury is suspected children's social care need to be informed so that consideration is given to the safety of the child in the hospital and any other siblings who remain at home. For these reasons as well as the clinical care of the child, it is important to avoid delays in diagnosis on the basis the child is perceived to be 'safe' in hospital.

7.2.15 Some delay was associated with both real and perceived limitations to expertise at the week-end: hospital staff need to be aware of the sources of out of hours expertise so that services are provided regardless of time of day or the day of the week.

7.2.16 This case highlights the need for consistency of review by the consultant on call, to ensure a consistent overview is available.

Working with parents and carers

7.2.17 All agencies need to develop a culture that involves working with both parents, including both in discussions and meetings about concerns and assessments and consistently following up allegations.

Multi-agency work

7.2.18 Communications between out of hours services may involve unknowns due to emergency circumstances, but when decisions are required about action to safeguard children, such discussions need to involve supervising police officers.

7.2.19 In order to maximise the quality of core assessments, all agencies should be asked to be involved in contributing up to date information and participating in the analysis process as well as the subsequent planning.

7.2.20 Practitioners in all disciplines and agencies need to understand that medical assessments do take account of social concerns and in particular any concerns about suspected abuse: these may affect the medical investigations undertaken.

7.2.21 GPs provide a universal service for all children and should have all key information about children and carers. It is vital that they are involved in the multi-agency child in need and child protection system. The fact that this is not happening either between agencies or within health is a critical concern and there needs to be clarification about what should be shared and who is responsible for sharing information with the GP, both within the health service and with other agencies.

Focus on children

7.2.22 This case has highlighted that when staff have responded in emergencies they have not always thought about checking on the family composition and the potential implications for siblings.

Planning

7.2.23 The use of written agreements is useful in so much as it makes expectations clear to all parties, and is helpful in any subsequent legal proceedings. However, without contingency arrangements and stringent multi-agency monitoring they are of limited use, and can give a false sense of re-assurance to staff.

Social Care records

7.2.24 The national implementation of the Integrated Children's System caused considerable upheaval in Buckinghamshire and most local authorities. Whilst some of the disruption was temporary, the staff in Buckinghamshire (like elsewhere) work with a very complex record system in which it is difficult to easily identify the relevant history of a case and the current circumstances.

7.2.25 The system has additionally had unintended consequences due to its linear design, which may place obstacles in moving into child protection once a child in need approach has been followed.

7.2.26 For staff needing to obtain information in an emergency, such as the Out of Hours staff, it is challenging to obtain pertinent data in a short space of time. Moreover, because the system is designed to capture relevant information about children, it will take considerable time to put together relevant history and concerns about an adult, or indeed a family. This is a potential risk to safe practice.

Supervision

7.2.27 Social workers and their managers need to develop skills in being able to combine analytical and emotional thinking, when assessing the care of children and in particular the risks to them. Reflective supervision and/or mentoring should assist front line staff to make use of such emotions in their work.

8 RECOMMENDATIONS

8.1 INTRODUCTION

8.1.1 8.2 provides the recommendations arising from the overview report which are not already covered in the individual management review recommendations 8.3.

8.2 OVERVIEW RECOMMENDATIONS

RECOMMENDATION	INTENDED OUTCOME
All agencies	
The LSCB to develop a local Framework for Assessment to provide a sound basis for multi-agency assessment	• The child protection threshold to be identified earlier, when the risk of significant harm is suspected (in accordance with the law) as opposed to when there is evidence of significant harm • Multi-agency involvement in assessments information collection, analysis and planning
The LSCB urgently to establish if the joint investigative work in this case is indicative of current practice	• Establish via audits in whether the practice shortcomings are due to individual errors or a reflection of systemic problems • If individual problems, this can be addressed via training and supervision • If systemic problems, there will need to be strategies implemented to improve practice so that such investigations are more likely to identify what has happened to a child
The LSCB to ensure a new joint investigative protocol is agreed between all agencies	• To include the role of all agencies • To consider how to bring rigour into the investigations so that forensic evidence is followed up, that all medical investigations are completed and that the risks to all children in the household / family are considered • To ensure strategy and review is of high standard • To ensure that decisions to return children home have considered fully the risks and are not based on assumptions • To ensure that agencies are updated when there are changes of circumstances to a child subject to an open s.47 enquiry and criminal investigation
The LSCB to facilitate the development of a culture which includes working with both birth parents as well as any carers	• Fathers not excluded from meetings, without sound rationale • Fathers informed of any concerns about their children • All allegations about care of children are followed up
The LSCB to develop a strategy with the new clinical commissioning groups to bring GPs into the centre of child safeguarding	• Information is fully shared with GPs • GPs share information • GPs involved in s.47 enquiries and in core

RECOMMENDATION	INTENDED OUTCOME
	assessments
The LSCB to encourage a culture of critical thinking around domestic abuse, which facilitates the identification of all relevant risk factors.	• Training courses on domestic violence / abuse to emphasize the dangers of falling into 'pitfalls' by making assumptions based on simplistic stereotypes • Training courses on assessment to provide an understanding of critical thinking • Training courses on reflective practice to emphasise the use of critical thinking in challenging assumptions and potentially rigid thinking
C&F	
A review should be undertaken of the current C&F electronic care record	• ensure the records are user friendly • ensure that information is easily accessible for staff in an emergency • record includes summaries and adequate chronologies • adult records include easily accessible information of historical concerns relating to children and parenting capacity
The use of written agreements to be clarified and understood within all agencies	• Prevent false sense of re-assurance when it is not possible to ensure safety • To only be used when the risks are able to be monitored effectively • all involved practitioners to receive a copy with expectation of involvement in monitoring • contingency arrangements clarified within agreement
Health	
The system for identification of vulnerable pregnant women and foetus to be reviewed	• Ensure pertinent information from health visitors and GPs records is communicated to the midwifery service
The LSCB to be informed of progress in achieving the Healthy Child Programme in respect of antenatal contact by health visitors	• That there continues to be improvement in the percentage of families receiving this service • That families identified as vulnerable are able to be prioritised for the service

8.3 INDIVIDUAL MANAGEMENT REVIEW RECOMMENDATIONS

Children and Young People: Children and Family Services (C&F)

RECOMMENDATION	INTENDED OUTCOME
C&F should work with other agencies to ensure that it becomes standard practice for Assessments to be multi-agency.	Children will benefit from the specialist knowledge and expertise of each agency, and outcomes will improve from the Plans set up with multi-agency involvement.
Ensure all staff are using the up-to-date version of the Children in Need procedures,	Children would benefit from a clear Plan and work pathway, the expectations of which would be clear to all relevant professionals.
The use of Written Agreements should be reviewed so that they are limited to being a tool ensuring clarity of expectations for parents or young people, and the professionals in C&F interventions.	It will be generally understood that Written Agreements are not interventions: children cannot be protected by a Written Agreement especially when the outcome depends on the compliance of relevant adults.
When C&F make a written agreement with parents or young people copies should be sent to other professionals involved in the case, unless there is a specific reason why this should not happen.	This ensures that relevant professionals are aware of the expectations on the parents.
C&F with TVP should review and revise the existing Joint Investigation Protocol and ensure that SWs are updated and that the Protocol is available for reference. Once an updated protocol is agreed Training to organised as part of the revision of the Protocol about joint investigations – not just ABE training	Both agencies are committed to working within a Joint Investigation framework, are clear about roles and responsibilities. When these are not adhered to there is a clear process for professional challenge.
ICS fast-tracking facilities should be made available so that it is possible to move from Referral or Initial Assessment (or other points in a case) to CPCC without having to complete a set sequence of forms to progress the record.	The workflow will be simplified so that it is more flexible and SWs do not have to complete forms unnecessarily, so that there can be a focus on professional judgement and the analysis of risk.
When a document is stored on Livelink, an ICS record which notes where it is stored on LL must always be made.	The Child's electronic record evidences the child's journey.
As part of the planned practice changes there should be a focus on developing systemic understanding of Domestic Abuse and the dynamics of this in families. This should include pro-active work with the abuser, and if a parent who is no longer in the family is described as an abuser this should be explored with them as an extension of the	SWs will be assisted to analyse the dynamics of the adult relationship, so that the victim is not under pressure to protect their children when the abuser is exploiting their vulnerability. There will be an assessment of the parenting abilities of the victim, including the negative effects of the relationship on their parenting. Abusers will be also be assessed and given the opportunity to change

dynamics, rather than accepting the description given.	
When an adult who has been the reason for children being subject to CP plans is found to have moved in with a new family: A Child Protection Conference for the children in the new family should be considered. If there are reasons why this is not necessary, these must be discussed with a CP Chair before making a decision not to hold a CPCC. The CP Chair (and the Core group) for the previous family should immediately be made aware of the circumstances, and continue to share information	The extreme vulnerability of babies will be part of general CP understanding. There will be stronger measures taken to protect babies when suspicious injuries have been identified. Senior managers and C&F legal will support SWs in these cases, even if action has to be taken when evidence (as opposed to risk) is not definite as this can be the difference between life and death.
Guidance should be developed with the assistance of health in regard to risk to babies, and workshops to be set up to circulate the guidance	The extreme vulnerability of babies will be part of general CP understanding. There will be stronger measures taken to protect babies when suspicious injuries have been identified. Senior managers and C&F legal will support SWs in these cases, even if action has to be taken when evidence (as opposed to risk) is not definite as this can be the difference between life and death.
Risk assessment guidance tool should be developed to improve the analysis of categories and levels of risk and evidence. Risk analysis to be clearly evidenced in recording and in CPCCs	This will improve the protection of children, and work being done by C&F will be more appropriate to their needs.

Health Overview

RECOMMENDATION	INTENDED OUTCOME
Midwifery services to review discharge procedures and information sharing between hospital and community services	To ensure that there is a mechanism for information sharing regarding vulnerable families particularly when there has been a premature delivery.
NNU to review discharge policy	To ensure that the mechanism for sharing information regarding child protection concerns with GPs is strengthened.
NHS Buckinghamshire to seek assurance that the paediatric department has completed a review of its procedures in cases of suspected non-accidental injury and to report implementation of recommendations made from this SCR and the internal review.	Appropriate timely action is taken by suitably trained staff to meet the needs of children in cases of suspected non-accidental injury

GP recommendations

SURGERY SPECIFIC RECOMMENDATION	INTENDED OUTCOME
The monthly liaison meetings with the health visitor team should continue and cancellations be avoided	Improved communication to ensure the highest level of care for all.

This case should be discussed at Surgery 2's next Significant Event Review Meeting focusing on communication between agencies.	Learning points should be identified and acted upon and communication between agencies improved.
RECOMMENDATION	**INTENDED OUTCOME**
General Practitioners should put Case Conference minutes, when received, in BOTH parents notes and those of the siblings too.	To ensure parenting capacity can be assessed to safeguard children in the future, especially when parents are registered at different surgeries.
General Practitioners should be encouraged to read the GMC's new Child Protection Guidance	Improved awareness of GPs of Child Protection to ensure Bucks Children are safeguarded

Health visitor recommendations

RECOMMENDATION	INTENDED OUTCOME
The Health Trust to review the current record system RiO, on how families can be linked together so that all family members can be identified.	Staff to revisit basic RiO training to understand how this can be done.
The Health Visiting team to review processes for information sharing and communication with GP's.	HV to explore how monthly practice meetings can be utilised to include discussion about the dynamics in family units and ensure that any safeguarding issues are considered for every child in the family.

Midwifery

RECOMMENDATION	INTENDED OUTCOME
Access for GPs to BHT maternity guidelines.	All professionals working to an agreed standard practice.
Review of the process for complex discharges from the postnatal ward, to ensure all relevant information is relayed to the community midwife and GP. Sharing of these findings with the hospital and community midwives	Early warning to the relevant professionals that there are concerns. To use the learning from this case at the mandatory child protection updates. It highlights how a breakdown in communication with the multi–agencies can lead to far more complex scenarios.

Hospital

RECOMMENDATION	INTENDED OUTCOME
Clear pathways for information sharing when children present with suspected NAI between professionals within health between agencies	To ensure that a child whose safety and welfare is at risk is protected from harm.
Child Protection Supervision for the Paediatric Department	Consistency of child protection procedures to ensure all children coming through the

	department are equally safeguarded.
Improve Medical record keeping Documentation in the records at the time the events happen, or as soon as possible afterwards. Record concerns, including any minor concerns, and the details of any action that has been taken, information shared and decisions made relating to concerns. E-mail communication between professionals to be filed in the notes -re information that may be relevant to keeping a child safe is available to other clinicians providing care to them.	Help improve the information we have on the child, enabling improved care including safe guarding.
Consideration to be given on how staff in the hospital could contribute to the parenting assessments.	Help improve on the multi-agency working to support child and family.
Full set of medical notes should be made available to the clinician undertaking a child protection medical.	Ensure a comprehensive assessment of medical and social needs.
Consider whether a quieter setting (compared to PDU) would be better to carry out child protection medicals	Enable the clinician to work in a less stressful environment
Strengthen the hand over process between Paediatric consultants.	Ensure continuity of care
Training need analysis of the child protection training arrangements for the medical team	To indentify appropriate training to keep up to date with child protection procedures.
Paediatric consultant to review any child on the ward in whom there are social concerns /known to social care	Senior clinician input will help improve patient care.
In children under the age of 2 years where physical abuse is suspected , a full skeletal survey should be performed	Ensure consistency in child protection investigations.

Thames Valley Police

RECOMMENDATION	INTENDED OUTCOME
Recommendation 1 – That a reminder be circulated to all staff, reinforced in ongoing training, that non-engagement in the DASH risk assessment process should in fact raise the risk level not decrease it.	Improvement to TVP DASH risk assessment process
Recommendation 2 – A reminder be circulated to all TVP staff and included in ongoing training that a DASH risk assessment must be conducted at every domestic incident attended irrespective of how recently one has previously been completed.	Improvement to TVP DASH risk assessment process
Recommendation 3 – That all TVP referral sergeants be reminded of the need to conduct and review secondary investigations prior to conducting any strategy discussion. This will also	Improved information sharing by TVP to support safeguarding meetings

reiterate the significance of bruising in babies and the need to carefully consider such injuries when deciding who will lead any subsequent s.47 investigation.	
Recommendation 4 – All TVP staff to be reminded of the need to ensure full details of any person taking over care of a child or vulnerable person are recorded and the necessary police checks are conducted on these.	Compliance with safeguarding requirements when placing child in care of family member
Recommendation 5 – That TVP undertake work to further explore the current approach to harassment offences, particularly the use of 'first case harassment' warnings as a resolution action. This will need to include the role of current Criminal Justice procedures and supervisors in the decision making process.	Improved response to harassment offences reported to TVP ensuring effective use of enforcement options available
Recommendation 6 - That TVP circulate clarification to all TVP staff clarifying that all out of hours multi-agency safeguarding liaison must be conducted by a supervisor. This must be structured to ensure the purpose of the contact is made clear from the start and include an agreed 'out of hours safeguarding management plan' that will be in place until a follow up review is conducted by the daytime team.	A more robust out of hours referral process

Adults and Family Wellbeing (Adult Social Care)

RECOMMENDATION	INTENDED OUTCOME
1. Review the requirement on staff to contact the OOH team when a referral is made to determine if it should be retained and enforced to ensure compliance.	A proportionate system is agreed, in place and complied with to ensure referrals contain the key information required for effective involvement, decision making and risk management.
2. Ensure all duty staff can access livelink Clearly identify and set out any client information which cannot be accessed by members of the OOH team and on what basis.	OOH staff can access all key records required to effectively carry out their roles and duties. Where access is not required that this is also identified, explained and agreed. For example issue of sessional worker access to livelink.
3. OOH staff to raise instances where key data is missing from referrals and records with C&F staff dealing with data recording quality control aspects of practice.	Referrals to OOH clearly set out the support required from the team. Client. ICS consistently provides sufficient information to enable effective working, decision making and risk assessment
4. Summaries of key data and or recent chronologies for records kept on the ICS See recommendations in section 8 above.	Key information held in relation to adults is made more accessible to all staff that need to, or are required to access social care records.