Local Child Safeguarding Practice Review

Alex

REVIEW REPORT

Considered by the Hartlepool & Stockton-on-Tees Safeguarding Children Partnership on 1.11.19 and 20.1.20

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1 Introduction to the case and summary of the learning from this review

1.1 This review is in respect of a three-month-old baby to be known as Alex[1]. Alex was taken to hospital twice on 2 April 2019; firstly following a reported choking episode and secondly with seizures. The baby was later diagnosed with a subdural haematoma (bleed on the brain) and a healing rib fracture, which were determined to be non-accidental.

1.2 Alex had been born prematurely. The parents and older sibling were already known to a number of agencies in Stockton-on-Tees, having recieved early help support and a social work assessment following a domestic abuse incident. When Alex was born the support being received by the family was largely universal and those involved had no concerns.

1.3 The learning identified from this review is in relation to:

[1] The name Alex was chosen with the parents. It was specifically chosen as the HSSCP did not want to identify the gender of the baby.

- Information sharing, seeking and clarifying, including of information provided by family members
- The need to reflect on the cumulative impact of all known information and concerns

2 Process

2.1 Following a rapid review process[2] and consultation with the Child Safeguarding Practice Review Panel, the HSSCP recognised the potential to learn lessons regarding the way that agencies work together to safeguard children by undertaking this Local Child Safeguarding Practice Review.

2.2 It was agreed that this review would be undertaken using the SILP methodology, which engages frontline staff and their managers in reviewing cases and focuses on why those involved acted as they did at the time, avoiding hindsight bias. Agency reports are completed where agencies have the opportunity to consider and analyse their practice and any systemic issues. They provide details of the learning from the case within their agency. Then a large number of practitioners, managers and agency safeguarding leads come together at learning events[3]. All agency reports are shared in advance and the perspectives and opinions of all those involved at the time are discussed and valued. [4]

2.3 The review considered in detail the period from 1 August 2017 – 16 April 2019, which covers the pregnancy with Alex's older sibling, until two weeks after Alex's injuries. The review was extended beyond the date of the injuries in order to consider the professional response, including the safeguarding of Alex's older sibling.

2.4 Detailed family information will not be disclosed in this report[5], only the information that is relevant to the learning established during this review.

2.5 Early family engagement is required in the SILP model of review. The lead reviewer spoke to Alex's parents during the review and at the end of the process. Their views have been considered at each stage and are included in the report where relevant.

3 Family structure

3.1 The relevant family members in this review are:

Family member	To be referred to as:
Subject child	Alex
Mother of Alex	Mother
Father of Alex	Father
Older sibling	Sibling

3.2 Any other family members considered will be referred to by their relationship to Alex, for example 'Paternal Grandmother'.

[2] A rapid review is undertaken in order to ascertain whether a local child safeguarding practice review is appropriate, or whether the case may raise issues which are complex or of national importance and if a national review may be appropriate. The decision is then made by the national Child Safeguarding Practice Review Panel.

[3] The lead reviewer was appointed, the terms of reference were agreed, agency reports and a chronology were requested, and two events were held to engage with staff in September and October 2019. The lead reviewer is Nicki Pettitt, an independent social work manager and safeguarding consultant. She is an experienced chair and author of serious case reviews and a SILP associate reviewer. She is independent of the HSSCP and all local agencies.

[4] The same group meet again to study and debate the first draft of this report. Later drafts are also commented on by all of those involved and they make an invaluable contribution to the learning and conclusions of the review[4].

[5] Statutory Guidance expects full publication of local child safeguarding practice review reports, unless there are significant and justifiable reasons why this would not be appropriate. It is important to ensure the anonymity of the family within this report.

3.3 Alex lived with both parents and Sibling after spending time in the hospital neonatal unit. Both children are currently in the care of the Local Authority. It is not yet possible to state the impact that the injuries will have on Alex's longer-term health and development.

4 The background prior to the scoped period

4.1 Neither parent was born in the area. Father moved to the area prior to starting secondary school, and Mother moved when she met Father in her late teens. There was social work involvement with Mother when she was a child, including a period on a child in need plan. She lived independently in temporary hostel type housing at age 16. Some professionals involved with the children had it recorded that Mother had been in care or a looked after child, but there is no evidence that this was the case.

4.2 As children, both parents lived in households where there was domestic abuse. It was not known prior to the injuries on Alex that domestic abuse was an issue in Father's early childhood. Mother also had a previous intimate relationship where domestic abuse featured.

4.3 Mother had a history of anxiety and depression. Father had physical health issues that impacted on his ability to work and on his mental health.

5 Key episodes

5.1 The time under review has been divided into five 'key episodes.' These are periods of intervention that are judged to be significant to understanding the work undertaken with a child and family. The episodes are key from a practice perspective rather than to the history of the child, so they do not form a complete history, but will summarise the significant professional involvements that informed the review.

Key episodes	
1	Early help
2	Response to domestic abuse concerns
3	Sibling's attendances
4	Birth of Alex
5	Response to the injuries

Key episode 1: (Early Help)

5.2 The reported financial difficulties during Mother's pregnancy with Sibling led to early help support from a Citizen's Advice Bureau (CAB) worker after the family were signposted by the health visitor. They were later referred on to the Children's HUB (CHUB)[6] by the CAB worker when the financial difficulties led to a risk of homelessness due to rent arrears and benefit issues. Appropriate advice was given to the referrer and financial support was provided.

5.3 Mother reported to the health visitor that the couple's relationship with Father's parents had broken down, apparently in part due to Father's financial issues and their concern about Mother's pregnancy. Mother alleged that there had been an incident where Paternal Grandmother physically assaulted Father during an argument.

5.4 In the months following sibling's birth there were no concerns regarding the baby's care from either parent.

[6]Local authority children's services, police, health, education and domestic abuse professionals work together in the CHUB. They consider the needs of children who are referred to them against the threshold document 'Providing the Right Support to Meet a Child's Needs in Hartlepool and Stockton-on-Tees'. The CHUB is the front door to support from children's social care.

Key episode 2: (Response to domestic abuse concerns)

5.5 Concerns were first shared about domestic abuse in the relationship in March 2018, when an anonymous referral was made to the CHUB. It alleged that Father was controlling, isolated Mother from her family, and that Mother wanted to leave him. The health visitor was asked to speak to Mother about the concerns, as she was involved with the family at the time. On her next visit in May the health visitor discussed domestic abuse with Mother and had no concerns. She was aware from a previous visit that Mother had been concerned that there may be a malicious referral made.

5.6 In June 2018 Mother rang the police and reported a domestic incident, stating that Father had left the home but was still outside the property. The couple told the police officers who attended that there had been an argument regarding whose turn it was to feed seven-month-old Sibling. Father allegedly threw water from the baby bottle at Mother. Father agreed to leave the vicinity at the police officers request. No further complaint was made by Mother, although she told officers on the scene that Father sometimes struggled to control his emotions.

5.7 Following the incident, Father contacted the police and the Emergency Duty Team (EDT) saying he needed to return to the family home. Mother had attended hospital for pregnancy related concerns and had been told that she would not be released without reassurance she had support at home. As a result of this hospital attendance a further referral was made to the CHUB by A&E, who recognised that Mother had a child, was pregnant, and that there had been a domestic abuse incident. A strategy meeting was held followed by S47 enquiries and a social work assessment[7].

5.8 During the single assessment that followed Mother said there had been unreported domestic abuse in their relationship in the past when Father had on one occasion pushed her and on another kicked her. She stated that he also sometimes struggled as Sibling could be difficult to feed, and that he had once 'force fed' Sibling. Despite this, Mother was insistent that she believed Father to be a really good partner and parent.

5.9 A Signs of Safety meeting was held with both parents, which also involved the paternal grandparents, social care and the health visitor and incuded a safety plan. The plan[8] included an expectation that both parents attend individual counselling with Starfish Health and Wellbeing[9]. It stated that they would be referred for sessions at Harbour[10], a local domestic abuse support service, when they had completed their counselling at Starfish. It was part of the plan that they would have support from the health visitor with feeding, and that they could attend appropriate parent and child groups and a weaning group. The midwifery service was not formally involved, this was because Mother had not yet booked in for the pregnancy with Alex.

5.10 The case was closed to CSC, with the parents stating that they did not wish for further support via child in need. Shortly afterwards another anonymous referral was received. The information shared was about domestic abuse and the risk they believed this posed to Sibling. It was also stated that the paramedics had been called to the home as Sibling had 'gone limp' when Father had 'refused to let go' of Sibling. The Children's Hub completed checks with the ambulance service and they advised that they did indeed attend, and that

[7] Child in Need assessment S17 Children Act.

[8] The safety plan refers to a section of the signs of safety meeting which was undertaken as part of the on-going assessment.

[9] Starfish deliver Primary Care Psychological Therapies for Adults including evidence-based Interventions for common mental health problems, such as depression and different forms of anxiety (e.g. OCD, panic and social anxiety). They also deliver treatment for trauma, such as EMDR.

[10] Harbour offers an adult outreach service, a children's outreach service, refuge, a preventions programme and the Freedom Programme.

it appeared to those involved that Sibling was simply exhausted from crying. They had no concerns. As the assessment which had recently closed had explored domestic abuse and did not identify any safeguarding concerns, a decision was made by CHUB to close the referral without further action. The information was not shared with the health visitor or midwife who were involved.

Key Episode 3: (Sibling's attendances)

5.11 Sibling was taken to either the Urgent Care Centre (UCC) or Accident and Emergency (A & E) on 17 occasions. On five of these occasions, when Sibling was between 6 months and 11 months old, a head injury or a report that he had bumped his head was either the primary reason for the visit or spoken about during the visit. (For example on one of the occasions he had been brought to the department for vomiting and Mother reported that he had hit his head two days previously.) None of the attendances were considered a safeguarding concern, either due to physical abuse or lack of supervision.

Key Episode 4: (Birth of Alex)

5.12 Alex was born prematurely at 31 weeks gestation and was in the neonatal unit for 26 days. There were no concerns expressed by staff on the unit about the family. Following discharge, a neonatal nurse visited the family a number of times and liaised with the family health visitor (but not the GP). It is reported that both parents were always present at home visits and there were no concerns. The health visitor undertook a primary visit and it is documented that the parental relationship was positive and that interaction between parents and baby was 'warm and loving'.

Key Episode 5: (presentation at hospital)

5.13 When Alex was three months old, they were taken to A&E by Father after reportedly being floppy and unresponsive following choking on milk during an early morning feed. After being admitted to the paediatric ward, appropriate observations and checks were undertaken. No marks or bruises were evident and there were no other concerns. It was thought that Alex had reflux and they were discharged home after successfully feeding and appearing well. Alex was given open access to the ward for the next 24 hours.

5.14 Alex returned with Father around two hours later suffering from seizures, which were observed on the ward. The baby was intubated and ventilated then transferred to a regional hospital with a Paediatric Intensive Care Unit (PICU). The PICU team requested that a CT scan be performed prior to transfer, but this was not possible due to the equipment being temporarily out of service. When the CT scan was undertaken following transfer, acute subdural haematomas[11] were identified. This led to the appropriate referrals being made and a timely strategy meeting between the police and EDT (as it was outside of office hours). Further imaging undertaken when Alex was well enough found a rib fracture. This was thought to have been caused around 10 days previously.

5.15 Sibling was staying with Maternal Grandmother while the parents were at the hospital with Alex. Checks were undertaken with the EDT for their home address and it was said that while there were no concerns about Sibling staying that night, a long-term placement would not be appropriate.

5.16 A child protection medical examination was undertaken on Sibling a week later.

[11] Blood clots on the brain

6 Analysis and learning

6.1 From the information gained within the agency reports, from the discussions at the learning events, and from speaking to family members, the following analysis enabled the review to identify learning for the HSSCP and local agencies. It was recognised that learning was identifiable in two areas, firstly in the response to the known risk and vulnerability and secondly in the response to concerns that emerged at the time. Each learning point is linked to a recommendation in either this report or within the agency reports.

Themes
Response to known risks and vulnerabilities
Response to concerns

Response to known risks and vulnerabilities

6.2 There are factors in a parent's background which can potentially present a risk to a child. These include issues that were evident in this case, such as domestic abuse, parental mental health, adverse childhood experiences, young motherhood[12], and estrangement from the new mother's own parents. Pathways to Harm, Pathways to Protection; a Triennial Review of Serious Case Reviews (SCR) 2011–14[13] points out that risk factors like these '*appear to interact with each other creating cumulative levels of risk the more factors are present'*. As well as the need to reflect on the cumulative impact of the parents own vulnerabilities, there was a need to consider the cumulative impact of what was happening in the family prior to Alex's injuries. This is considered in the second theme below and led to learning from the review.

6.3 Domestic abuse featured in both parent's childhoods, in Mother's previous relationship, and in their relationship. The Triennial Review found that '*domestic abuse is always harmful to children'* and that '*professionals should not rely on victims of domestic abuse to act for their own or their children's protection'*. Father did not disclose his own childhood experiences until after Alex's injuries. When Mother met with the midwife to book in for her pregnancy with Sibling, she told her midwife that there had been domestic abuse in her own family and with a previous partner. This was documented within the antenatal records. Mother disclosed the domestic abuse incident between Mother and Father during the early pregnancy with Alex when she booked in for her second pregnancy, and this was recorded. There is no evidence that Mother was asked directly whether she may be suffering from on-going abuse in the relationship with Father during either pregnancy. The agency report is clear that Father was present for nearly all antenatal contacts which would have made asking the question difficult. However, there was no evidence of a documented plan to see Mother alone, as is expected. Women should be informed at booking that she will be seen on her own at least once in pregnancy, and there should be a visit on or around 16 weeks to ask about domestic abuse. A single agency recommendation has been made to review the current pathway and should improve practice in this area.

6.4 The agency report for the midwifery service also notes that there is minimal information regarding Father in the midwifery notes, although it is recorded that he was in attendance for the majority of Mother's antenatal appointments. During Mother's pregnancy with Alex there was a change in midwifery caseloads and staff sickness which may have had an impact.

[12] It was known that the parents were young (aged 18 and 19) and in a fairly new relationship when Mother became pregnant with Sibling. The average age of first-time mothers whose children were the subject of a SCR was age 19 (the same age as Mother in this case), compared to the national average of age 28 for first time mothers.

[13] P. Sidebotham and M. Brandon et al. (2016)

Alex was also born prematurely at 31 weeks which reduced the timescales for visiting, assessment, and supervision. One of the midwives involved was aware that support was being provided by the CAB worker and she spoke with her, there was no conversation between the health visitor and midwife however. This would have been particularly useful following the domestic abuse incident during the pregnancy with Alex. (Learning point 1)

6.5 Mother didn't share any information about domestic abuse between her and Father with any professional until she was spoken to following the domestic abuse incident in June 2018, when she shared that Father could get angry and struggled to manage his emotions, and that she had been pushed once and kicked once by him in the past. She told the lead reviewer that the relationship was not generally abusive. At the time those involved believed that Father took responsibility for not always managing his feelings, including when he was spoken to by the social worker who undertook the single assessment. Signs of Safety was used during the assessment and both parents agreed to attend counselling sessions at Starfish. There is some confusion about whether the parents missed appointments following the individual assessment sessions that were completed. The parents told the review that there were issues at Starfish at the time and that they were not informed of changes to the appointments. There is no evidence that their lack of attendance was shared with any other agency except the GP, and they did not share it further. The health visitor was not informed of any issues with attendance, although the parents had told her that they had cancelled an appointment when Alex was born early. The health visitor did not contact Starfish directly as she believed they would not discuss the case with her. It is likely they would have provided information if asked, and if the health visitor had the parent's consent. This was not pursued. The learning from this review highlights the need to check information provided by parents, with their consent **(Learning point 1)** and consideration about who will be responsible for supporting the family to enable them to continue with the agreements made during the signs of safety process on case closure to Social Care. In this case there was limited consideration of the impact of both parents receiving counselling and what this might mean for their relationship and parenting. **(Learning point 2)**

6.6 In the second pregnancy the midwife has documented that Mother was receiving support from Starfish. It is acknowledged that the size of midwife's caseloads and the restrictions of clinics mean that not all information provided can be checked, and there was no reason in this case to believe that sessions were not being provided to the family. As the planned attendance at Harbour to address the domestic abuse was to happen following the completion of the Starfish sessions, the success of the Starfish support was significant. Until Harbour was able to get involved no work was being undertaken with the parents regarding the domestic abuse. The review was told that there is a view locally that Harbour will not provide a service if clients are receiving counselling from other services[14]. In this case it was considered that the couple needed to complete individual counselling before they attended domestic abuse support. There was no agreement at the end of Social Care involvement regarding if and how attendance should be monitored and what should happen if the parents did not attend Starfish. **(Learning point 2)**

6.7 Father had physical health issues that were often problematic to manage, with no effective treatment. His ill-health impacted on his ability to work and he reported feeling depressed because of this and the resulting financial difficulties. He was prescribed antidepressants by his GP while Mother was pregnant with Sibling. The health visitor was aware of the impact on his mood, and told the review that they discussed this regularly, although this isn't recorded.

[14] And vice versa. Other counselling services wouldn't work with people who are receiving support from Harbour.

The health visitor said that they do not record sensitive information about partners in a mother's notes, but if there is an impact on the child this should be recorded in the child's record. The health visitor was clear however that it was her view at the time that the parents were managing well and that there was no negative impact on the child/ren. The review has found that Father's health issues are part of the cumulative vulnerabilities within the family at this time however. **(Learning point 3)**

6.8 The 2011 thematic report on learning from Serious Case Reviews, Ages of Concern[15] focused on babies due to the high proportion of reviews that are completed on children under one. The report identified recurring messages from the reviews and found that the *'risks resulting from the parents own needs were often underestimated, particularly given the vulnerability of babies.'* The report also found that there was a need for improved assessment of, and support for, parenting capacity. At the time of Alex's birth, the family had two children under 13 months old. The time following discharge was potentially going to be stressful for the family, and Alex had been born prematurely, had a low birth weight, and developed difficulties with feeding due to intolerance of cow's milk. This added to the potential cumulative risks in the case. The agency report completed for this review that considered the 0-19 service states *'the pressures of caring for an unsettled premature baby would have been emotionally demanding particularly when the parents also had a 14-month-old baby and limited family support.'* The health visitor acknowledged the potential issues and visited them more regularly than most families to support them at this time.

6.9 Mother had been prescribed medication for anxiety and depression in the past. She was not thought to be suffering with post-natal depression although she was in a high-risk group for this. The health visitor undertook screening of Mother at the appropriate times and there were no concerns. Less was known about how Father was managing with the transition to becoming a parent. This is something that is rarely discussed with men in a family, with the professional focus usually being on the mother. There is evidence that the health visitor engaged with Father however, and he was due to get support from Starfish as it was acknowledged in the safety plan and by Father himself that he required therapeutic support. In this case Father appears to have been seen as a co-parent by those involved, and the safety plan considered the need for both parents to receive support. This is good practice. There is increasing evidence of father's suffering with post-natal depression[16] and they also require support and the opportunity to meet with professionals, including on a one to one basis.

Learning:
1. Information regarding parental history and any information on the children known by <u>all agencies</u> should be sought, shared, checked and considered. This includes checking information provided by parents, sharing information with the safeguarding nurse for the midwifery service if a pregnancy is known or suspected, and robust information sharing between midwives and health visitors. This is particularly important when there has been previous involvement from Social Care.
2. There needs to be clarity across agencies when a case is closed to Social Care regarding what should happen if any concerns emerge or if the family do not continue to cooperate with any agreement made at closure. This should include the midwifery

[15] Ofsted 2011

[16] Research available from the National Childbirth Trust found that more than 1 in 3 new fathers (38%) are concerned about their mental health. In general, studies have shown that one in 10 fathers have PND and fathers also appear to be more likely to suffer from depression three to six months after their baby is born.

service if there is a pregnancy.
3. The cumulative impact of parental risks and vulnerabilities should be considered in assessments and when working with a family.
Good practice:
• The extra support provided by the health visitor. • Father was acknowledged as an equal parent. He was included in assessments and provided with support.

Response to concerns

6.10 There were a number of occasions where concerns or potential concerns had to be responded to by professionals. They were:

- The 'anonymous' allegations of domestic abuse from a family member
- The domestic abuse incident
- Mother's allegation of domestic abuse
- Mother's allegation of 'force feeding'
- Siblings attendances at UCC and A&E with 'head injuries'
- Alex's hospital admissions in April 2019
- Consideration of both children following the above

They will be considered individually.

6.11 The plan recorded by the CHUB on closing the case following the first anonymous allegation was that the health visitor would speak to Mother about the allegation was a proportional one. Professionals are aware that speaking to a potential victim about domestic abuse while the potential perpetrator is present can exacerbate risks, so telephoning Mother out of the blue about the issue was not necessarily appropriate. The health visitor was known to be providing regular support, so it was a good plan for her to find a way of discussing it with Mother. There was a recorded contingency plan that if the health visitor was unable to do, or if she was concerned about the family, she should re-refer to the CHUB. Mother had previously told the health visitor that that a family member might make malicious allegations, but the health visitor made sure that she saw Mother alone the next time she visited and recorded that Mother had made no disclosures.

6.12 The second anonymous referral was made via a third party, but it was known that the information was being shared by the same person who had made a referral before. As the case had recently been closed with a safety plan in place and checks with the paramedics had not raised any concerns, it was agreed to take no further action. The information shared and decision made was not communicated with those who were continuing their involvement with the family however, such as the health visitor, the midwife or the GP. A new baby was due, and research shows that domestic abuse can increase when a woman is pregnant. This means that the midwife was particularly key. She would be seeing Mother through her pregnancy. As the midwifery had not been involved at the time the safety plan was drawn up, they may not have been aware of the plan, and they were not informed that a new referral had been made. They were therefore potentially working with the family without the benefit of knowing the history and vulnerabilities. If the case is not yet allocated to a midwife, information should be shared with the safeguarding nurse for the midwifery service if a pregnancy is known or suspected. **(Learning point 5)**

6.13 During the domestic incident response in June 2018, a DASH[17] Risk Assessment was completed by the attending police officer. The couple were categorised as Medium Risk by the officer and this was agreed by the supervisor. Medium risk is where *'there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, loss of accommodation, relationship breakdown, drug or alcohol misuse.*' This appears to be an appropriate grading. Mother told the officer about historic previous violence from Father to her, which involved him pushing her. This is the first indication she had given any professional of any physical abuse in the relationship. The officer was also aware that Mother was pregnant.

6.14 In the meantime, Mother had attended hospital with unrelated abdominal pains the day after the incident. The hospital made a SAFER referral as they were aware there had been a domestic abuse incident. However, the midwife was not informed of this attendance despite the hospital 'attendance in pregnancy pathway' stating they should be. This means the midwife (or safeguarding nurse for the service if the case had not yet been allocated) was not made aware of the incident. No referral outcome was shared with the hospital and the hospital staff did not follow the referral up, despite the safeguarding children policy stating that referrals should be followed up by the hospital within 48 hours.

6.15 A strategy meeting was held which led to a S47 enquiry. After the enquiries were completed within child protection procedures and it was agreed the case did not meet the threshold for a child protection conference, Sibling became subject of a child in need single assessment, to be completed by the social worker, which was appropriate. Both parents were engaging, and a number of positive and protective factors were identified. When the assessment was completed, which included a signs of safety 'safety plan'[18] devised with the parents and the paternal grandparents. There was a recommendation that on-going support be provided to the family with Sibling as a Child in Need, but the family did not believe they needed this, and consent is required. The health visitor was involved in the signs of safety meeting. The GP records for Sibling and both parents had details of the domestic abuse incident and response. This is good practice. The absence of information sharing with the midwifery service was a gap however.

6.16 Despite sharing that Father had been physically abusive on two occasions when he pushed and kicked her, Mother stated during the social work assessment that she was happy in the relationship and that Father was a good partner and parent. Father showed a degree of insight into his need to manage his emotions and agreed to get support. Mother had told the social worker that Father struggled when feeding Sibling and that he had 'force fed' the baby. It was known that Sibling had intolerance to cow's milk and feeding issues following their birth. Clarification was sought by the social worker completing the section 47 enquiry and single assessment. Father denied force feeding Sibling, and Mother said she meant that Father had tried to get the child to eat by placing the food against the baby's mouth. The social worker undertook a clear interview with Mother and made sure she described exactly what had happened. They concluded that that there wasn't any undue force used, and there was no visible injury. Taking into consideration Sibling's reflux and milk allergy it was recommended that the health visitor should provide advice and guidance with feeding, which she did.

[17] Domestic Abuse, Stalking and Harassment and Honour-based violence risk identification, assessment and management model.
[18] Using the Signs of Safety model of intervention.

6.17 The parents were regular attendees at the UCC based at their local hospital and at A&E. The review was told that families living in the locality have a tendency to use the UCC at the local hospital as an alternative to accessing primary health care at the GP surgery. This is likely to be attributable to the close geographical location between where the family lived, and the UCC and A&E (which is in the same location). On five of the occasions in fairly close succession Sibling had recorded injuries to the head, for example a red mark to the top lip on one occasion and an abrasion to the forehead on another. The review considered these a high number of injuries in a child who is not walking. Each injury or reported incident was considered and the explanations were thought acceptable.

6.18 The first presentation resulted in the appropriate consideration of whether the injury was non-accidental and whether the Bruising in Immobile Baby Procedure[19] should be followed. As Sibling was said to be rolling over and therefore considered mobile, the 'injury' was not significant, and the nature of the injury was consistent with the reported mechanism[20] use of the procedure was not required.

6.19 The review has found that while none of the injuries appear to be suspicious, ACHILD[21] was not completed following all of the presentations and therefore there was no opportunity for them to be considered for any pattern. To enable the 0-19 service to consider cumulative concerns, they have an existing significant events process that should have flagged Sibling's attendance to A&E and UCC, therefore leading to a risk assessment and informal supervision to consider possible safeguarding concerns. Single agency learning and a recommendation has been made in relation to this. **(Learning point 3)**

6.20 When the second of Sibling's recorded head injuries was seen at A&E, the case was open to the social worker following the domestic abuse incident. No details of the attendance were passed to the Social Worker, who was told about the attendance by the parents during a subsequent home visit. They told the social worker they had been told that there was nothing to worry about, so no checks were undertaken by them. There is no system in place in A&E or the UCC that will flag or provide alerts if children have a child in need plan or are open to children's social care. Hospital staff are reliant on parents to inform staff that they have a social worker involved. Completing ACHILD would provide a prompt for practitioners to enquire if there is social care involvement. The review was told that if A&E staff become aware that there is social care involvement then a 'sharing of information' form is usually completed. The child's GP and the 0-19 services are notified of all attendances and receive a discharge letter after each attendance, but this did not result in a consideration of the wider picture for Sibling, despite there being a new baby on the way. According to the health visitor this is because at the time any notifications on children not receiving a targeted service were scanned onto the child's record by an administrator and are not always brought to the attention of the health visitor. There was previously a 'significant events pathway' that flagged on the system if there were over 3 attendances in a short period of time. The system became overwhelmed however because of the number of attendances at UCC particularly, so this no longer happens. This does create risk in the system as important information can be missed by those working with children and families.

[19] The procedure states '*Any injuries are unusual in this age group, unless accompanied by a full consistent explanation'*.
[20] The Tees 'Immobile Baby Procedure' clearly defines what would class as immobile.
https://www.teescpp.org.uk/specific-issues-that-affect-children/bruising-on-non-mobile-babies/
[21] A&E screening tool to identify potential safeguarding concerns

The relevant health service was asked to consider this dilemma and they have made an additional single agency recommendation[22].

6.21 When there are a number of issues over time it is important to a child to consider whether there is a safeguarding issue emerging, for example rough handling or lack of supervision. While none of the injuries in themselves were likely to have met the threshold for a child protection intervention[23], consideration of the wider picture would have been helpful, along with looking at the incidents together to consider if there were cumulative concerns. This will not always be possible in an acute setting, so there is the need to ensure that those in community health services are aware of the attendances. **(Learning Point 4)**

6.22 The parents in this case are likable and plausible. They come across as open and honest and they have a loving relationship with each other and with the children. Regardless of what is being seen, professionals need to ensure they triangulate what parents are saying by establishing the facts, gathering evidence, and communicating well with all involved. There is a need for all professionals to have a conscious and healthy scepticism[24]. While there were examples of good information sharing in this case, there were also areas where this could be improved and where there could have been clarification or checks. It is important that professionals share information and communicate to ensure that they do not solely rely on parental self-report. **(Learning point 1)** If information is not shared, professionals need to question this and challenge each other. It is recognised that there are a number of barriers such as time, staffing, and navigating data systems. **(Learning Point 8)**

6.23 The GP was not spoken to during the S47 investigation following the domestic abuse incident, despite Mother and Father having lived elsewhere and the GP records being the only likely place where relevant background information was available. GPs should always be consulted to inform a strategy discussion and subsequent investigation/assessment. **(Learning point 6)**

6.24 When Alex was seen in hospital on 2 April 2019 systems were checked and there were no alerts on the health care records. Sibling's records were not checked, as it is not practical to do this in all cases when a baby is admitted. It is clear however that even if those making decisions about Alex on the first presentation had information about the domestic abuse (and potentially about Sibling's repeat presentations with head injuries), it is unlikely that a different decision would have been made regarding the discharge of Alex after an appropriate period of observation.

6.25 Alex was very unwell on the second presentation and appropriate medical interventions took place. Following the results of the CT scan and the acknowledgement of the possibility of the issues being due to a non-accidental injury, there was a timely safeguarding response. Sibling was considered and a proportional decision was made to leave them with local members of the family overnight. There followed a disagreement about when to undertake a medical on Sibling. The Social Care position was that until there was certainty about Alex's injuries being non-accidental there were no grounds to undertake a medical (and potentially a scan) on Sibling. However there is rarely complete certainty regarding a non-

[22] A related issue was that it took some time during the review to establish the number of attendances and this was largely due to the information systems used in A&E and the UCC. This is likely to have an impact on the ability of professionals to be able to look at cumulative concerns and patterns during and following a presentation.
[23] It should be noted that all of the attendances were considered by a medical expert during the care proceedings and none were thought to be non-accidental injuries.
[24] Lord Laming. The Victoria Climbie Inquiry. (2003)

accidental injury. As stated by Munro in 2010[25], "uncertainty pervades the work of child protection."

6.26 While there were no concerns for Sibling's health at the time, it was important to the investigation and their well-being to see if Sibling had any injuries. CSC had ensured Sibling's protection by agreeing that they should not remain with family members beyond the first night. They then completed the required checks of the alternative family members who took on care and supervised contact with the parents. In regard to the medical there was some confusion about what was being requested. The Social Care team believed that an 'intrusive' skeletal survey was being requested rather than a 'non-intrusive' child protection medical. The exact nature of the expected medical should have been clarified at the time and agreement reached to avoid the delay. **(Learning point 7)**

6.27 Alex was appropriately safeguarded when they were well enough to leave hospital.

Learning:
6. The cumulative impact of any incidents or concerns should be considered. This requires information sharing and peer discussion, effective systems for reviewing any notifications, and reflective supervision.
7. At the point of closure information should be shared with those continuing to work with the family. Including midwives, if there is a pregnancy. Any new information that emerges, including further anonymous allegations, should also be shared.
8. GP information should be considered as part of a strategy discussion and additional information sought as part of the assessment.
9. Strategy discussions should always include consideration of whether siblings require a Child Protection Medical as per the the Tees Child Protection Medical Procedure.
10. Professionals should always be alert to whether assumptions are being made about a family and whether any professional disagreements need resolving formally.
Good practice:
• Well considered and timely responses from the CHUB • The referral from A&E when Mother attended following the domestic abuse incident • The care of Alex during their admissions to the local hospital were timely and responsive, and the Consultant Paediatrician sought advice from the Named Doctor for Safeguarding • Good communication between agencies and across borders in key episode 5 • Contact between Alex and the parents was sensitively supervised in hospital • Open access was given to the paediatric ward for 24 hours, so that the baby did not need to return to A&E if there were further concerns • Checks were undertaken with another local authority out of hours • Good attendance at strategy meetings • Thresholds are well understood and upheld • There has been a high degree of cooperation and engagement from agencies with the review process, which has been important in identifying the learning

[25] The Munro Review of Child Protection – Part One: A Systems Analysis; Department of Education 2010

7 Recommendations

7.1 The rapid review process that recommended this review identified a number of issues that required consideration. They included information sharing, Sibling's attendances, and parental history. The review has found that while it was known that Alex and Sibling were living in a home where domestic abuse and low level parental mental health were known to be a factor, they also appeared to be well and lovingly cared for and their home was clean and warm. The parents stated they were willing to work with professionals and came across as open and honest. The review has considered the known parental history, the emerging concerns including the domestic abuse incident and allegations, the families financial and health stresses, a number of presentations with Sibling at A&E and the UCC, and two very young children with reported feeding issues. The review has found that none of these concerns would have met the threshold for an on-going child protection response, even if considered cumulatively. There were however opportunities for improved information sharing, for more focused support of the family, and for agreement about how the parent's engagement with on-going therapeutic support would be monitored.

7.2 It is recognised that actions have already been taken in relation to some of the individual agencies' identified learning in this case. For example work is already underway within the hospital trust to improve completion rates of ACHILD which includes robust audits and increased visibility of the safeguarding team within UCC and A&E.

7.3 The agency reports have made recommendations which have largely been completed by the conclusion of the review. Some of the learning identified within this report will have been addressed by the single agency actions plans, which are being monitored by the HSSCB 'Engine Room'. They include recommendations such as community midwives needing to be reminded that pregnant women should be seen alone at least once in pregnancy to enable routine enquiry regarding domestic abuse to take place, and that they need to be made aware of when to seek advice and guidance or safeguarding supervision from the safeguarding team.

7.4 The following recommendations have been agreed by the HSSCP in response to the learning identified during this review:

1. That HSSCP continue to reinforce via workforce development the importance of:
    - understanding parental history and how this informs known risk and vulnerability (Learning Point 1)
    - consideration of cumulative impact within assessments (Learning Point 3)
    - information-sharing at case closure and if new information emerges (Learning Point 5)
    - GP information being sought (Learning Point 6)
2. That HSSCP produce a 'Seven Minute Briefing' for the multi-agency workforce which outlines the learning from this case review, to be disseminated and promoted across all agencies.
3. That the HSSCP audit cycle should continue to review best practice in relation to assessment, including the consideration of cumulative concerns.