Serious Case Review

Child L

Significant non-accidental injuries to a young baby

Wiltshire Safeguarding Children Board

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Context

In August 2018, Child L was admitted to hospital and was placed in intensive care with life threatening injuries. She was three and a half months old. Her Father has been convicted of GBH and sentenced to 9 years in jail. The injuries sustained by Child L were such that they meet the criteria set out in 'Working Together 2015' for a Serious Case Review (SCR).

An alternative model for this review was agreed. Following the completion of the required Rapid Review, agencies agreed to foreshorten the traditional SCR methodology of "commission – review – delivery to practitioners". Instead it was agreed that the involvement of practitioners (through 4 multi-agency workshops) would constitute the review itself and that we would use those workshops to discuss the case, explore the issues and identify some ways forward: the workshops were the SCR. These workshops were independently facilitated by Research in Practice (RIP) and involved 82 participants from a range of agencies. The outcome from those externally facilitated workshops form the basis of this review which has been authored by the Independent Chair, Mark Gurrey with support from the LSCB (as was) Quality Assurance Lead, Julie Upson who is also independent of the partner agencies involved.

The workshops were constructed to:

- promote reflection and objectivity; become one's own internal supervisor to enhance hypothesis generation, analysis, reflection and critical thinking in assessment and intervention
- set out the importance of forming effective relationships and the crucial role played by observation
- encourage the adopting an 'eyes wide open', strengths-based approach with outcomes for children in clear sight and mindful of misplaced or unevidenced optimism
- ensure hearing and understanding the family's history and story (including fathers) within an attachment and systems framework
- ensure practice is narrative not episodic
- encourage a culture of urgency, with courageous conversations (with families and colleagues) from the outset

An evaluation of the process followed and is included at the end of this report. One key finding however, worth stating here, was that the evaluations of the workshops evidenced that 98% of participants rated the content quality as very high and the likely impact on practice as very high/high(98%).

Family Background and Case Summary

Child L	Subject of this report aged 3 and a half months at time of injury
Child B	Half sibling of Child L and sibling of Child C aged 4 years
Child C	Half sibling of child L and sibling of Child B aged 7 years
Mother	Mother to Child L, Child B and Child C, aged 31 at time of incident
Father	Father of Child L, aged 21 at time of incident, serving soldier
Adult D	Mother's ex-partner and father of Child B and Child C
Paternal Grandparents	Parents of Father, living in another local authority area with their 2 other children, none of whom were previously known to children's services or the police

Mother, Child B and Child C were known to children's social care and had previously been subject to periods of Child in Need and child protection planning as Mother was a victim of domestic abuse from Adult D. Mother had a history of depression and suicidal threats and on several occasions made threats to kill herself and Child B and Child C whilst drunk. She was described as an "alcoholic" and disclosed that

both her parents had been heavy drinkers and that she had been binge drinking since the age of 18. She was assessed by both mental health and substance misuse services and offered support. However, her engagement with these agencies was inconsistent and sporadic. Eventually, because of poor engagement, support from the substance misuse service was removed and she was provided with an online service only for a period of time.

Mother became pregnant with Child L following a short relationship with Father, a serving soldier living in Barracks when they met. Concerns were raised throughout the pregnancy about Mother's alcohol consumption by the Midwife and Mother told professionals that she was attending her mental health appointments and accessing support for her alcohol dependency. The midwife completed two MASH Referrals and a single assessment was completed to assess Mother's drinking and the impact of this on her unborn baby. The outcome of this assessment was that the case sat below Child in Need (CiN) status and a Family Key Worker from the Council's Support and Safeguarding Service was allocated. Child L was born at the end of April. The case was closed in May 2018 and although a CAF Early Help Assessment was discussed as part of the step-down process, agencies deemed this was not needed. Child L was spending weekends with her Father at his parent's house at this point.

By June 2018 concerns about Mother's mental health and drinking resurfaced and there were a number of crises events that resulted in Strategy Discussions and Section 47 enquiries. It was agreed that Mother was to have no unsupervised contact and a safety plan was put in place. This included the agreement that Father was not to return Child L to Mother's care if Mother was intoxicated. The support from Maternal Uncle and a friend of Mothers' to supervise Mother's care of Child L quickly broke down and it was agreed between Mother and Social Worker that Child L should remain in the care of her Father. Child L was made subject to a child protection plan at the end of July, under the category of neglect. At this point Child L was being cared for by her Father and Grandparents at Paternal Grandparents' home and had started attending a local nursery.

Injuries and bruising to Child L were observed on three separate occasions between 6th and 15th of August: the first was observed by the nursery; the second by Mother at the Contact Centre; the third again observed by the Nursery. On August 19th Child L was admitted to hospital with life threatening injuries. Child L had been in the sole care of Father at the time, he was not able to provide an explanation for the injuries and was arrested for GBH with intent.

Child L is now in Foster Care. She has significant neurological impairment resulting in profound disabilities. Child B and Child C are living with Adult D.

Case Analysis

Concerns relating to how agencies worked together begin during the pre-birth period. There is evidence of over optimism by agencies in relation to Mother's ability to control her drinking and engage with support services. Midwifery spoke directly to the substance misuse service to find out if Mother was engaging with them in the way that she was reporting and were persistant in raising their continued concerns regarding her use of alcohol. In addition, there is no evidence of any agency exploring the reasons behind Mother's drinking despite her disclosure of her own childhood experiences and domestic abuse whilst in a relationship with Adult D. It is not clear from the chronologies reviewed that information shared between Health Visiting and Midwifery within meetings was recognised and recorded appropriately. This meant that there was no opportunity for targeted ante-natal visits earlier on in the pregnancy.

The outcome of the single assessment completed following the referral from the midwife was that the case should sit at Support Level, between Early Help and Child in Need. The assessment lacked a critical view of Mother's history and insufficient focus was given to whether a more formal statutory level of intervention was warranted. Although there were regular multi-agency meetings including key professionals, the case remained managed at too low a level with the current and future risks not well defined as part of a robust multi-agency assessment.

Following the birth of Child L, Support and Safeguarding and Health Visiting were reassured by Mother's assertions that she was not drinking, did not feel the need to and was happy and coping. Considering Mother's history, this was very optimistic and suggests a lack of understanding of addiction. Mother has since said that in fact she was not coping at this time and needed continued support. This optimism by professionals resulted in the case being closed just 3 weeks after Child L's birth.

Mother was the focus of concerns by all agencies with Father and his family seen as protective. However, there is little reference to him being in meetings and references to him in assessments appears limited. It is stark that within the agency chronologies reviewed as part of the Rapid Review there is no evidence of Father actually being spoken to until June 2018. Contact with agencies was often through Paternal Grandparents and Child L was often in their care whilst Father remained in Barracks. No agency ever challenged this view of 'good Father vs bad Mother' – the drive to find a safe(r) placement for Child L appeared to override a fuller assessment of Father. As a result, it was agreed that Child L would be cared for by Father without any assessment of either his parental capacity or indeed that of Child L's Grandparents and there was little observation of any of them with Child L. No agency knew how much time Father had spent independently caring for Child L whilst living with her at the family home. The home LA did not inform the LA in which Child L was now living that she was a child subject to a child protection plan, which would have been good practice.

The response to the bruises and injuries in the week leading up to Child L's admission to hospital was of concern and did not follow procedure. The nursery was not active enough in ensuring the social worker knew about them and Father's explanations on two occasions were accepted with no further assessment or examination sought. Even though the nursery was not made aware by the home LA that Child L was subject to a child protection plan the expectation would have been that the bruising was responded to and reported appropriately. A further bruise was noted by Mother whilst at the Contact Centre; again, this was not appropriately reported and Father's explanation accepted. There was a significant failure in not reporting these injuries and bruises and highlights the importance of ensuring all professionals understand

the significance of bruising in non- mobile babies, are able to retain a respectful doubt about parental explanations in such circumstances and are confident in the reporting process. Relevant Safeguarding Partners will need assurance that issues regarding reporting of bruises by agencies have been addressed within the nursery and other settings.

Agencies Involved

As part of this review the following agencies were contacted to provide information and their staff attended the practitioner workshops:

- Adult Mental Health Services
- Local Authority Families and Children's Services
- Health Visiting Service
- Children's Centre
- Salisbury Hospital NHS Foundation Trust
- GP Surgeries for both Mother, Father and Child L, Child B and Child C
- University Hospital Bristol NHS Foundation Trust
- Police
- Adult Substance Misuse Service
- Contact Centre
- Army and Unit Welfare
- Nursery in neighbouring local authority area (where Paternal Grandparents lived)
- Children's Social Care in neighbouring local authority area (as above)
- Out of Hours GP Service

In addition, a Case De-brief workshop was held attended by 20 practitioners and line managers directly involved in the case.

Views of the family

Mother, Father and Paternal Grandfather have contributed to the review.

Mother identified the period just after the birth of Child L as difficult: the case was closed 4 weeks after Child L's birth. From Mother's perspective all agencies were saying everything was going well and Mother described not feeling confident enough to disagree with this view and say that she was not OK; that she was struggling and was worried she might have post-natal depression. Mother could not identify if there were things that professionals could have done to make her feel more able to speak out about how she was feeling at this time.

A few weeks after the case had closed Mother was drunk whilst in the care of Child L. Mother described professionals' viewing this incident as a "blip" rather than an indication that she was finding it hard to cope. Mother felt that if support been put back in place at this time this may have made a difference. Within a couple of weeks there was another incident where Mother was drunk whilst in the care of Child L and it was at this point that arrangements were made for all her children to be cared for by their respective fathers. She had no family she could fall back on to provide supervision of her care of Child L which meant there was little choice but for Child L and her other two children to live elsewhere. Child L was less than 2 months old at this point and Mother said that it was very hard to be separated from her when she was so young, even though she now recognises that she would not have been able to care for

her at that point. Mother also felt that she was not kept up to date about when the children might be returned to her care or about how Child L was, and this led to her feeling excluded. She did not know that Child L was attending nursery until the incident and would have liked, for example, the Health Visitor to phone her to tell her about Child L's progress. Mother felt that had there been a suitable mother and baby unit available this would have helped her to get well whilst continuing to be able to care for Child L.

Father was spoken to in prison and he described feeling overwhelmed by the circumstances of becoming a new father in the context of a difficult relationship with Mother and disruption of his army career. He said he did not feel able to talk about how he was feeling with professionals. No professional came to visit him at his barracks and had they done so he stated that he may have felt more able to be open. He said that his relationship with Mother became very difficult after the birth of Child L and this added additional pressure to the situation.

Father also commented that he did not feel he understood his rights as the father of Child L, for example understanding that he had parental responsibility and that it was not just the mother who could make decisions about the child. As a new father he was shown the Dad pad, but he described this as being unappealing and not something he would have referred to.

Paternal Grandfather also contributed to the review. He shared the view that his son's voice had not been fully or properly heard in the work and, conversely, that too much weight was given to Child L's mother. He and his wife had been active in Child L's care when she moved, and the injuries occurred when they were on a long-planned holiday to Florida. Needless to say, they remain devastated by what happened to her.

Findings from this review and response to learning

Wiltshire has not waited for the review to conclude before acting on the learning and action has already been taken in relation to some of the learning from this case:

- The Midwifery/Health Visitor Pathway has been revised and relaunched
- Multi-agency Protocol on Bruising and Injuries in Non mobile Babies and Children has been revised in the light of this case and relaunched across the agency network. The new protocol and guidance includes a Leaflet for parents which has been well-received by professionals in supporting their confidence in following the guidance.
- Wiltshire has also undertaken a thematic review into significant physical injuries to children under 1yr . The circumstances of Child L and learning from this case have been incorporated into this review.

Learning from the workshops: Practice Themes

There were four major practice themes inherent in this case that emerged from the practitioner's workshops. These are set out below including some detail about how they manifested in this case and the agreed enablers that could help address them and improve practice outcomes.

Theme 1 - Communication and Information Sharing

Issues

- Reluctance or lack of confidence in phoning other agencies and checking things out
- Not knowing who to contact either individual or agency; understanding roles because of service changes

- Being able to articulate concerns clearly – to parents/in referrals and assessments/ in case notes
- Being heard and feeling listened to; confidence to challenge - if we don't have this how do we create it?

Responses

- List of local agencies and contact details – this to be kept electronically to aide updating and accessibility
- Shadowing of roles in other agencies as part of induction and professional development
- Sharing prompts for language to use in referrals and other useful tools/guidance: " if nothing changes the impact on the child will be …"
- Good record keeping – for yourself but also for others taking over a case
- Make use of **'**My conclusions are … my evidence is ….'
- Being clear and concise
- Summarise/reflect back what has been said (to both parents and other professionals)
- Prepare scripts for conversations
- Say and write what you mean
- Clarify consent to share information

Theme 2 - Early Support

Issues

- Reluctance to initiate an Early Help Assessment – seen as onerous and burdensome
- Services actively discouraged not to initiate (focus on their core purpose and early help assessment not seen as part of this)
- Lack of ownership across agencies
- TAC meetings poorly attended – so commitment to attend falls
- Lack of available services to support even if needs are identified

Responses

- Development of the Early Support Hub within Wiltshire MASH
- Roll-out of the revised Early Support Assessment and shared IT systems as part of FACT Project
- Improve understanding and ownership of the Early Support Assessments function as a multi-agency framework for working together and sharing information about a child and their family

Theme 3 – Curious and Holistic Practice "To get the whole picture we need to know the whole family"

Issues

- Don't want to upset families – don't have the emotional capacity to get into a difficult conversation
- Assuming others have done it
- Understanding the difference between information and evidence
- Starting with and retaining a fixed mind set/bias
- Have concerns that remain but don't know what to do with them
- MASH seen as the place where all information is held

Responses

- Clarify role of MASH in logging and storing information
- Use of genograms
- Revisit difficult questions (e.g. keep asking about domestic violence)

- Use tools to help analyse the information you have and what type of information it is (e.g. Wonnacott's Discrepancy Matrix; Socratic questions)
- Good supervision and use of tools in supervision to reflect on cases
- Describe what we see/hear
- Hypothesising
- Understand the why and the when (e.g. in relation to substance misuse not about what and how much)
- Respond to feelings not the words; they need to feel their concerns are being listened to and addressed
- Time to ensure record keeping is comprehensive, clear and up to date
- Absence of thing is as importance as the presence
- Understand "so what makes me think that?" – evidence? Feeling?

Theme 4 - Working with Fathers/Male Carers

Issues

- Focus is always on mothers therefore we don't think about fathers
- Don't feel able to challenge fathers – what are you doing to support the mother of your child?
- Fathers often referred to as protective with no evidence for this or based on self-reporting by mother
- Fathers seen as either 'good = supportive' or 'bad = risk' – need to develop more balanced view
- Reliance on mothers telling us about fathers
- Some systems/documentation don't prompt questions about fathers

Responses

- Having systems that prompt you to record information
- Engage with men in their spaces
- Ask fathers questions – "how are you feeling about…?"
- Review content and use of Dad pad, including gathering the views of fathers to inform any improvements and updates
- Ask questions in supervision – "What about the Father in this case?"

Summary

In summary, this report sets out the circumstances that led to the significant injuries sustained by Child L and an analysis of the practice. Since this case was reviewed, there has been some significant development and investment in relation to a number of the learning themes, including:

- The identification of funding to develop a pilot project focused on engaging fathers and developing models of good practice
- External evaluation of the Support and Safeguarding Service by Oxford Brookes University with recommendations informing further service development as part of the Families and Children's Transformation Project (FACT)

In addition, the issues highlighted in this report have been picked up in a parallel report published by Wiltshire's Safeguarding Vulnerable People Partnership (SVPP) in November: Thematic Review in to Significant Physical Abuse in Children under 1. The learning from this review will be brought together with that from the Thematic Review and work will be undertaken, overseen by the SVPP, to ensure that learning is actioned.