Serious Case Review

Kirsty

OVERVIEW REPORT

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CONTENTS

1. Summary of the learning Page 3
2. Introduction to SILP Page 3
3. Introduction to the case Page 4
4. Family Structure Page 5
5. Terms of Reference Page 5
6. The Process Page 5
7. Background prior to the scoped period Page 6
8. Key practice episodes Page 7
9. Analysis by theme and lessons learned Page 15
10. Conclusions Page 28
11. Recommendations Page 32

Appendices

1. Terms of Reference and Project Plan
2. Agency Report pro-forma
3. Action Plan
4. Genogram
5. Learning Points from Baby Eve SCR Overview Report

1. Summary of the Learning

This Serious Case Review has identified a number of learning points for the individual agencies involved and for the Northumberland Safeguarding Children Board (NSCB). When considering in detail the involvement of NSCB partner agencies with Kirsty and her sibling Lydia it has found that:

- Where professionals observed behaviour or saw evidence to indicate that Kirsty or Lydia were at risk of harm in the majority of cases a timely intervention took place. Staff followed existing processes effectively.
- Assumptions were made about the level of protection that the Father could provide to his children.
- Professionals relied significantly on self-reporting from parents and did not consistently demonstrate professional curiosity, even when there was conflicting evidence to what parents were reporting.
- Changes to the way that injuries in non-mobile babies in Northumberland are now referred would have led to a referral to Children's Services regarding Lydia in July 2010.
- The family was not seen by the GP as having complex needs or being problematic which resulted in them not being referred for additional support. Mother was seen as having experienced significant life events which impacted heavily on her mental health but consideration was not given to how these problems would affect the children in the family.
- Assessments made of the family did not consistently draw on all the information that was available and key health professionals did not pass on or refer to Children's Services with their concerns resulting in an inaccurate assessment of the family situation.
- The significance of physical violence towards the Father from the Mother was not fully recognized by professionals.
- When the opportunity presented to hear Lydia's voice as part of the assessment process, professionals overlooked the insight she could give on being a child within this family.

2. Introduction to the Significant Incident Learning Process (SILP)

2.1. The NSCB agreed that this Serious Case Review (SCR) should be undertaken using the SILP methodology. SILP is a learning model which engages frontline staff and their managers in reviewing cases, focusing on why those involved acted in a certain way at the time. This way of reviewing is encouraged and supported in Working Together to Safeguard Children 2013.

2.2. The SILP model of review adheres to the principles of;

- proportionality
- learning from good practice
- the active engagement of practitioners
- engaging with families, and
- systems methodology

2.3. Nationally it has been generally accepted that in the past the SCR agenda had become over-bureaucratic and driven by Ofsted[1] ratings. The practitioners in the case have often

[1] Ofsted - The Office for Standards in Education

been marginalised and their potentially valuable contribution to the learning has been under-valued and under-utilised.

2.4. SILPs are characterised by a large number of practitioners, managers and agency Safeguarding Leads coming together for a Learning Event. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again to study and debate the first draft of the overview report, and to make an invaluable contribution to the learning and conclusions of the review.

2.5. Working Together 2015 states that SCRs and other case reviews should be conducted in a way which;

- recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- makes use of relevant research and case evidence to inform the findings.

2.6. This SCR has been undertaken using the SILP model which ensures that these principles have been followed and provides a systems review of the case.

3. Introduction to the Case

3.1. The subject of this review is a child to be known as Kirsty. She was 6 weeks old at the time that serious concerns emerged which led to the decision to undertake a serious case review. On 13th August 2014 Kirsty was seen at home by a Health Visitor who noted she had bruising to her left cheek. Children's Services were informed and Kirsty's parents were requested to take her to the local Hospital where they were met by a social worker. Following an initial paediatric medical assessment a decision was made for a full skeletal survey and further tests to be undertaken the following day and Kirsty was placed on a ward overnight. The survey revealed that Kirsty had 10 fractures of varying ages in her body. The medical opinion was that these injuries were the result of non-accidental injury. The injuries did not require treatment and Kirsty has made a full physical recovery and appears to be doing well.

3.2. NSCB recognised the potential to learn lessons from this review regarding the way that agencies work together in Northumberland to safeguard children. Working Together to Safeguard Children 2013 (the guidance in place at the time that the decision was made to undertake this serious case review) states that serious case reviews should:

- Identify improvements in the way that agencies work together for the prevention of death, serious injury or harm to children and to consolidate good practice.
- Clearly identify what lessons are to be learned both within and between agencies and within what timescale they will be acted on and what is expected to change as a result.

3.3. Kirsty lived with her mother and her father and her older sibling Lydia (4 years old at the date of the incident) and had irregular contact with her paternal grandparents. The family had been known to children's social care. Lydia had been the subject of child protection investigation following her mother's behaviour after her birth on 15th February 2010. The

case was formally closed in October 2010, however health professionals involved in the case had been informed in the March meeting that the case was to be closed. Mother was known to agencies due to mental health issues. The father was not known to services.

4. Family Structure

4.1. The child subject of this review is to be referred to as Kirsty and her sibling as Lydia.

4.2. The parents of the children are referred to in this report as Mother and Father. Other family members will be referred to by their family title e.g. Paternal Grandmother.

4.3. Mother and Father lived together with the children. They are thought to have been a couple since 2004 and had been married for seven years at the time of the incident.

4.4. The children and both parents are white British. Their only language is English. This information appears to have been accurately recorded on agency records. They have no known physical disabilities. At the time of the incident Father was working, but on a part-time basis.

4.5. At the time of Lydia's birth the Paternal Grandparents lived on the same street as Mother and Father.

4.6. A genogram is attached at appendix 4.

5. Terms of Reference

5.1 The detailed Terms of Reference and Project Plan appear at Appendix 1. The purpose, framework, agency reports that were commissioned, and the particular areas for consideration in this SCR are all described there. The case specific questions asked of the agency authors are listed in the Terms of Reference.

5.2 It was agreed that the scope of this review would be from May 2009 to 14th August to 2014. The latter date is when Kirsty was discharged from hospital.

5.3 Notwithstanding that Kirsty is the subject of the review, the scope was widened to test if there were lessons that could be drawn from the interventions by agencies following the birth of Lydia.

6. Process

6.1. The parents were contacted to ensure their views were considered and heard as part of the review. An appointment was offered on 2nd July 2015, and both parents agreed to meet the lead reviewer at their separate addresses. The key themes that emerged from both parents were the perceived lack of clarity of communication from services and in the second pregnancy and postnatal period they felt they were left to their own devices as the expectation was that they would be capable parents to Kirsty as they had parenting experience with Lydia. The lead reviewer met with Mother again prior to the publication of the overview report. The lessons learned, the good practice identified and the recommendations were shared with her. Mother requested that the report should reflect her view that she suffered severe headaches following her epidural at Lydia's birth and this is referenced in paragraph 8.10. Professionals from Children's Services and the Safeguarding Board visited Father prior to the publication of the overview report. He reflected that he had felt that professionals had focused their support towards Mother but acknowledged he had not sought help.

6.2. The Department for Education (DfE) expects full publication of SCR overview reports, unless there are particular serious reasons why this would not be appropriate. Working to that requirement, some confidential historical family information will not be disclosed in this report. It is written in the anticipation that it will be published, and contains all of the information that is relevant to the professional responses and contact with the family. The decision to disclose information has been taken with reasonable caution to prevent the identification of the children concerned and other family members, and to protect the right to an appropriate degree of privacy for the family.

6.3. The SCR was planned at a scoping meeting held on 19th March 2015 with the NSCB Serious Case Review sub-group. The Terms of Reference were compiled and the timescale for the review set. Agency reports were requested, along with a chronology of agency involvement. A briefing meeting for agency report authors was held the same day, to clarify expectations.

6.4. A Learning Event was held on 14th May 2015. All the agency reports were available and had been circulated in advance with the chronology. This ensured that all staff attending were able to fully understand the multi-agency information and focus of the review. The event was very well attended by practitioners and their immediate managers as well as NSCB Case Review Committee members and board representatives.

6.5. The Recall Event was held on 3rd July 2015. Participants who had attended the Learning Event considered the first draft of this report. They were able to feedback on the contents and clarify their involvement and perspective. All those involved contributed to the conclusions and the identified learning from this review.

6.6. The final version of this Overview Report was presented to the Northumberland Safeguarding Children Board on 15th September 2015. It has been agreed that some additions may be made to this report once the criminal investigation has been completed, including any further information that becomes available during that process and after engagement with the parents.

6.7. The Police investigation was on-going at the time of the Recall Event. Both parents had been arrested and a decision regarding charging them had yet to be made. Criminal proceedings drew to a close in January 2017. It was directed that Mother had no case to answer. Father offered a guilty plea and received a 12 month suspended sentence and was ordered to carry out unpaid work.

6.8. The children have been the subject of child care proceedings and live together with relatives who have been approved as foster parents. They are both said to be thriving in this placement.

6.9. The lead reviewers in this case are Nicki Pettitt, an independent child protection social work manager and consultant and Mark Granby, a safeguarding consultant, who is the author of this report. Nicki is an experienced chair and author of SCRs, and is a SILP associate reviewer. Mark is a retired police officer and an accredited SILP associate reviewer. Both are entirely independent of NSCB and its partner agencies.

6.10. Working Together 2013 does not require the completion of a health overview report which considers the commissioning of health services and in some circumstances may be helpful in pulling together the related health information. It was agreed with the NSCB that an additional review of this type is not required in this case, as there were no complex health commissioning issues that needed to be addressed.

6.11. The decision to undertake an SCR into this matter was made on 7th January 2015.

7. The background prior to the scoped period

7.1. Mother reports she was known to Children's Social Care as a child. Mother had reported to health professionals that she had been abused when living with her biological family and as a consequence had been taken into care. Mother also reported her older sibling was subsequently adopted when she was 3 years of age. From mother's account, she believed that there was also an older child, but they lost contact as a result of the sibling being placed with a different adoptive family. It is significant that the Social Worker involved with Lydia and with Kirsty did not seek to confirm the reports provided by mother through Children's Services records at the time although this process is now being completed to verify mother's reports of her care history.

7.2. When Mother was 17 years of age she requested access to Local Authority records to find out about her background and adoption. It was as a result of this enquiry that she discovered that both she and her sibling had had a traumatic childhood. Mother reported that this discovery resulted in her experiencing low moods.

7.3. Mother has been known to Mental Health Services since 2002 with an intermittent history of self-harm, suicide ideation and low mood. In 2003, Mother experienced another traumatic life event and the experience triggered further low moods, depression and self-harm episodes and she was prescribed medication for depression.

7.4. In January 2009, Mother's adoptive mother was diagnosed with terminal cancer. This diagnosis triggered another depressive episode resulting in Mother reporting to her GP that she was having suicidal feelings.

7.5. The Mother and children were registered at a different GP to Father. The Mother registered with the practice in 2003 and subsequently registered Lydia and Kirsty after their respective births. Father registered with his GP in 2010. Mother was a frequent visitor to her GP, predominantly reporting mental health problems.

7.6. There is no known relevant background information regarding Father.

8. Key Practice Episodes

8.1. The time under review has been divided into five Key Practice Episodes. Key Practice Episodes are periods of intervention that are judged to be significant to understanding the way that the case developed and was handled. The term 'key' emphasises that they do not form a complete history of the case but are a selection of the activity that occurred, and includes the information that is thought to be key in informing the review.

8.2. The first Key Practice Episode covers from February to March 2010. This includes the events around the birth of Lydia, the child protection investigation and assessment period by Children's Services and the decision to close the case.

8.3. The second episode covers May to July 2010, when the parents presented Lydia at Accident and Emergency with an injury and that Mother had disclosed to a community psychiatric nurse that she had shaken baby Lydia.

8.4. The third episode covers June 2012, when Mother was reporting mental health issues to her GP following the death of her adoptive mother and disclosed that her alcohol usage had increased significantly.

8.5. The fourth covers May 2014, the period just prior to Kirsty's birth when the community midwives notify Children's Services of the pregnancy through a referral.

8.6. The fifth and last Key Practice Episode covers the period from 8th August 2014, this includes the period up to and including the discovery of the bruising on Kirsty's cheek by the Health Visitor.

Key Practice Episode 1: from February to March 2010.

8.7. Health Trust records indicate that Mother frequently self-referred to midwifery services throughout Lydia's pregnancy. In fact she presented to maternity services on 10 separate occasions. She was seen by a number of midwives and doctors for pregnancy related complaints. Mother was referred to the High Risk obstetric clinic due to her previous history of self-harm, suicide ideation and her use of GP-prescribed anti-depressants. This was good practice.

8.8. The assessments indicated that this was a baby who had been planned for and who was very much wanted.

8.9. The Tynedale Health Needs Assessment that is usually undertaken by health visitors at the antenatal appointment was not carried out. This was due in part to parents cancelling two antenatal appointments and as a result of Lydia being delivered several weeks early.

8.10. Mother experienced problems with the epidural during delivery that caused her to report that she was experiencing severe headaches. This can be a complication of epidural.

8.11. When Lydia was born she was nursed on the Special Care Baby Unit for a number of days due to mild symptoms of withdrawal from anti-depressants and treatment for jaundice. It was during this period that midwifery staff became growingly concerned about the aggressive behaviour that Mother was demonstrating. Four separate incidences of aggression were documented on the three days following Lydia's birth. Behaviour observed included Mother kicking something in the room, potentially the cot, and swearing at baby Lydia. As a consequence of the concerns, midwives sought advice from the Health Safeguarding Team and subsequently a referral was made to Children's Services.

8.12. An initial assessment was carried out on the day of the referral which was good practice. A formal multi-agency strategy meeting was held the following day. Following the initial assessment meeting, it was agreed between the midwife and social worker that a mental health assessment for Mother should be requested to inform the overall process. The on-call psychiatrist was notified that a referral had been made to Children's Services due to the risk that Mother potentially presented to her baby. The psychiatrist spent a considerable amount of time with Father discussing Mother to assess her ability to care for baby Lydia whilst on the ward. A full mental health assessment then took place that indicated there were no significant mental health problems present. The psychiatrist discussed with Mother and Father a safety plan to be implemented upon discharge and this was shared with the ward and a copy sent to the GP. The psychiatrist was not invited to the strategy meeting although his views were shared at the meeting from the hospital notes, so although the psychiatrist was not there his assessment was shared with Children's Services and the strategy meeting. The safety plan included the following list of statements:

- strategies to cope with feelings of anger and irritation if the baby is crying
- asking for help if Mother feels she is not coping
- the ward have referred to CSC who will assist with any assessments and consider if any extra support will be required, a suggestion by the psychiatrist was for in-

creased contact with the Community Midwife and the Health Visitor who can monitor Mother's mood and her bond with Lydia. This suggestion by the psychiatrist of extra early help to monitor parenting capacity post discharge from the ward appears appropriate in the absence of a mental illness.

- no further mental health follow up has been arranged but a re-referral can take place at any time.
- anti depressant medication prescribed by the GP could be increased if Mother decides to stop breast feeding.

8.13. The child protection investigation revealed that Mother wished to go home but that baby Lydia was not yet fit for a medical discharge. Father was identified as a protective factor who was confident in his ability to calm Mother down and the Paternal Grandparents were very supportive and lived close at hand. Father had 4 weeks paternity leave available to him. It was also noted that Maternal Grandmother would be supportive.

8.14. The Strategy Meeting was well attended. The GP was unable to attend the meeting, but later provided some information verbally to inform the assessment process. The psychiatrist informed the serious case review that they were not aware that the meeting had taken place. Participants agreed that there was a need to undertake a Section 47 child protection investigation due to the risk of significant harm to Lydia. Two options for a safety plan were discussed. The first involved Mother and Lydia being referred to the mother and baby unit at a hospital where a full assessment could be carried out. The second involved allowing Mother and baby Lydia to return home with Father taking on the primary caring role for the child. In the event of Mother attempting to discharge herself and Lydia from the hospital before the plan had been finalised, it was agreed that the hospital should notify the police so that a Police Protection Order could be put in place. It was later established that the first option was not viable as the psychiatric assessment had not identified any significant mental health problems.

8.15. The Section 47 enquiry was completed on 19th February. It was noted that the concerns were substantiated however there no longer remained a risk of significant harm to Lydia. The decision was made to provide ongoing support and monitoring to the family and that Mother should not have unsupervised contact with the baby. The outcome of the Section 47 enquiry was not reported to have been effectively communicated to health professionals. Moreover, the plan did not contain detail to highlight the form that the additional support and monitoring would take, other than to include daily community midwife visits. Discussion with the parents revealed that they did not have a clear understanding of the plan. Specifically Father, who was identified as the primary carer, later reported that he was not aware of this expectation. Given that Father was on a limited period of paternity leave it was unrealistic to expect him to undertake full time supervision of Mother's care of Lydia.

8.16. Community midwives visited the family on a daily basis for 9 days following baby Lydia's delivery. No issues were noted and the parents were described as being positive. Social workers visited the family 3 days after discharge from hospital as part of the core assessment and Mother discussed her behaviour detailing that she would shout and throw things. She disclosed to the social worker that she had once hit Father but had been so shocked by this that it had never been repeated. The significance of this disclosure appears to have been overlooked. There was clear evidence of violent behaviour in the household. Moreover, the physical aggression that Mother admitted to subjecting the Father to was not seen as compromising his capability to effectively care for and protect Lydia. The first health visitor visit to the address took place on 24th February. The health visitor ensured that she saw

Lydia and reported on positive interaction between Mother and baby. Social workers carried out visits to the Paternal and Maternal Grandparents to assess their capacity to support the family. A concern raised by the social worker was Mother's ability to care for Lydia once Father had returned to work as he had been the primary carer.

8.17. On 9th March a review meeting was held with social worker, midwife and health visitor representation. It was felt that the family had adapted positively to the arrival of Lydia and that ongoing support for the family would be through universal services with health visitors being the lead professionals. In addition, grandparents advised that they would be providing ongoing support for mother. The following day social workers met with Mother and Father to inform them that there would be no further Children's Services involvement with the family. It emerged during this review that the Health Visitors were not clear of this plan, albeit there was the opportunity to seek clarification at the review meeting.

8.18. This is a Key Practice Episode because it was the first time that professionals could assess the impact that Mother's mood swings would have on her capacity to care for her child. It was positive that Mother had had a long standing relationship with her GP who knew her very well. The Level 1 Assessment by the community midwife correctly identified that Mother was adopted and there were self-harm and suicide ideation episodes. It was good practice that a referral was made to the high risk clinic by the midwife as a result of concerns for her mental health and BMI. There is rationale to explain why the Tynedale Health Needs Assessment[2] was not carried out during the antenatal appointment albeit this was regrettable. It has since been identified that the training provided to health visitors on completing the assessment did specify when it should be completed but it did not give guidance about when to complete it if it was not completed antenatally. It now outlines that the assessment is to be undertaken at the first available opportunity.

8.19. The decision taken by the hospital midwives to refer the family to Children's Services after observing Mother's behaviour was a good one. The level of detail contained within the referral represents good practice. The urgency of the response by social workers to the referral and the work done in completing the initial assessment was positive, as was the level of attendance at the first strategy meeting. However, the oversight in failing to invite the psychiatrist to the strategy meeting or to notify them of the referral did give rise to the formulation of an option that was not a realistic one. This pushed professionals down the path of the second option where Father was to take on the primary caring role for baby Lydia, supported by Paternal and Maternal Grandparents. There was insufficient detail in the plan to give all professionals who were working with the family a clear understanding of how their engagement was to deliver the additional support and monitoring that was assessed as being required. Professionals acknowledged that Father was protective towards Mother, notwithstanding her disclosure that she had assaulted him on one occasion. The plan placed considerable trust in the Father and Paternal and Maternal Grandparents to protect baby Lydia in the event of Mother experiencing a violent outburst. There is evidence to indicate that not all professionals engaging with the family had been informed of the outcome of the Section 47 investigation, this specifically included the GP who was the professional who had most contact with Mother.

[2] The THNA is an holistic, structured assessment tool designed for use in a conversational style to obtain qualitative information from the client.

8.20. The decision to close the case to Children's Services was taken on 9th March 2010 but the children and families assessment document that is triggered by the Section 47 investigation was not written up until October 2010. Some professionals at the Learning Event concluded that it was somewhat over-optimistic to close the case and that this sent a powerful message to Mother and Father that Children's Services were withdrawing, and that there were no longer any concerns.

Key Practice Episode 2: from May to July 2010

8.21. At the end of April 2010 Mother's GP sent a referral to the community psychiatric nurse. This followed a disclosure from Mother that she was feeling frustrated and angry towards the baby but she had 'not done anything'. This disclosure was not shared with the health visitor or Children's Services. Lydia would have been 10 weeks old at this time and Father's paternity leave would have ended and he would have returned to work.

8.22. The mental health assessment by a CPN took place on 25th May 2010. Two prior appointments had been cancelled by Mother. At the assessment Mother described that she had had a traumatic experience giving birth to baby Lydia and that she believed her concerns were dismissed by the midwives. This had left her feeling angry and she was overwhelmed by the responsibility of caring for a child and this resulted in her shaking her. Mother explained that Children's Services were involved but the case had been closed with no further action being taken. There are no records of the community psychiatric nurse acting upon this disclosure and it would appear that she took on face value from the Mother that this incident had been investigated by Children's Services. The disclosure was shared in a letter to the Mother's GP (this is referred to in the Primary Care agency report) who also appeared to have formed the view that the incident had already been investigated. This disclosure was not referred to Children's Services.

8.23. On 24th June 2010 the health visitor completed a home visit for the 4 month review. This was later than had been originally planned as the parents cancelled the first appointment and on the second and third attempts no one was home. The health visitor noted that Mother reported to be seeing the community psychiatric nurse and that she was feeling well. The notes show that the health visitor observed a lovely interaction between Mother and baby and that Lydia was meeting her developmental milestones. The plan was to visit the family again when Lydia was one year old, in line with the provision of universal services.

8.24. On 7th July 2010 Lydia, now 5 months old, was taken to Accident and Emergency by her parents. She had bruising to her face and left arm. The explanation given by the parents for the injury was that Lydia was being carried by her Father, he had fallen with her in his arms. The incident was not referred to Children's Services as it was felt by those involved that the injuries were accounted for by the explanation and the parents had sought timely intervention. This decision making was in line with the Trust's policy and guidance at the time, which stated that if there was a credible witnessed account for the injury and the circumstances were reviewed by the senior doctor in Accident and Emergency and there were no other known concerns, a referral to Children's Services was not required. The health visitor received a copy of the A+E sheet and was concerned about the injury but accepted that it had been an accident. In accordance with the HV guidelines '*Criteria when a home visit should be undertaken in babies under 12 months outside of the Healthy Child Programme 2009'* she assessed the action required and felt it was appropriate for telephone follow up. During this conversation she discussed the mechanism of the accident and safety in the

home with the parents. This was in accordance with Trust and Multi-agency guidance at the time.

8.25. This is a Key Practice Episode because there was a disclosure made to her GP by Mother that she was feeling frustrated and angry towards baby Lydia. The subsequent disclosure by Mother to the community psychiatric nurse that she had shaken baby Lydia presented an opportunity to reassess the risk that Mother presented to her baby.

Key Practice Episode 3: June 2012

8.26. Mother's adoptive mother died in 2011. In June 2011 Lydia was presented to Accident and Emergency by her parents as she was unable to weight bear. The explanation offered was that Lydia had trapped her leg down the side of the sofa. It was reasonable due to the lack of known concerns and that Lydia was a mobile infant without evidence of a significant injury, that the incident was not referred to Children's Services. At this time Lydia was 16 months old.

8.27. In September 2011 Mother reported to the community psychiatric nurse that she had been drinking 2 bottles of wine a day to help her cope with the loss but stressed she was now abstinent. At a follow up meeting a week later Mother reiterated to the clinician that she was no longer drinking. This appears to have been accepted on face value without consideration being given to the impact that such heavy drinking would have on her parenting. It also appears to have been accepted from Mother that she could move from such heavy drinking to abstinence. In January 2012 Mother was discharged by community psychiatric services and was reported as being much improved. However, in April 2012 Father contacted the GP as he was concerned about Mother's drinking. The GP referred Mother back to community psychiatric services in May 2012.

8.28. A new psychiatric assessment of Mother was undertaken in June 2012. In this assessment Mother disclosed to the consultant psychiatrist that she had been drinking two bottles of wine a day for a year in order to cope with bereavement issues. Moreover, she described her feelings of being tired, angry and unable to cope with her child. No further action was taken following this disclosure.

8.29. This is a Key Practice Episode because information was made available to professionals to indicate that Mother was not coping well after the death of her adoptive mother, and that she was drinking heavily to try and cope with her feelings. Adequate consideration did not appear to be given to the impact that this behaviour would have on Mother's capacity to care for Lydia or the risk of harm that Lydia could be exposed to. The fact that this information was not shared with Children's Services represents a missed opportunity. There was a lack of 'mindfulness' in thinking of the family and child and the impact that Mother's drinking and depression would have in the household.

Key Practice Episode 4: May 2014

8.30. In April 2014 Mother and Father attended an initial appointment with an Obstetrics and Gynaecology Psychologist. During this appointment Mother shared that she had experienced an episode of non-coping where she had shaken her first baby. Mother also advised that Children's Services were aware and had assessed the family. The psychologist documented this information and shared it widely but did not verify the information or consider the need for a referral to Children's Services. The conclusion of the psychology assessment was that Mother was not best placed within health psychology and she would be discharged from the service.

8.31. A referral was made to psychiatric services during the second trimester of Mother's pregnancy with Kirsty. Simultaneously, a referral was made to obstetrics and gynaecology health psychology, which was an inappropriate referral, it should have gone to perinatal psychiatry. Midwives now have yearly mandatory training from obstetrics and gynaecology health psychology and therefore pathways of referral are clear. Screening highlighted the error and it was rectified internally which should be seen as good practice. However, Mother failed to attend the appointment that was offered to her by perinatal psychiatry in early March 2014. This may have been due to Mother recovering from a surgical procedure at the end of February. As a result of Mother's failure to attend the appointment she was discharged from the service as not seen. The Consultant Psychiatrist sent a summary letter to the GP and midwife.

8.32. The community midwives made a referral to Children's Services on 29th May 2014 to alert them to Mother's pregnancy and the impending birth. The rationale for making this referral centred Mother's disclosure she had shaken her first child, that Mother no longer had the support of the adoptive Maternal Grandmother and on the issues surrounding Lydia's birth and that a crisis intervention was required after the delivery. The midwives reported that they had very little information available to them to highlight their perceived concerns. The referral made reference to Mother having 'tantrums' on the ward after Lydia's birth and included a reference to the history of self-harm, suicide ideation and depression. A CAF had not been completed. The decision was taken that this would be managed by way of contact with the family but no further action is to be taken.

8.33. On 30th May 2014 a social worker made telephone contact with Mother. During the contact call Mother outlined her disappointment at the referral and that it made her feel like a failure as a mother, although she did concede she had a difficult time following Lydia's birth. She recognised that the arrival of a new baby may cause some challenging behaviour from Lydia. Mother said she had good support from Maternal Grandfather and Paternal Grandparents and that the Father would be taking 4 weeks paternity leave. She had met with the health visitor and believed she had good contact with the midwife. Given this support network, Mother felt there was no need for additional support. This intervention would have provided a better assessment of the family's needs had it been informed by more sources of information.

8.34. This is a Key Practice Episode as it presented professionals with an opportunity to share relevant information to assess the capacity of Mother to care for a new baby along with Lydia. It is apparent that all the information that was held by professionals was not effectively shared as not all key professionals fed into the assessment process and reliance was made on the information held by the community midwives and Children's Services. The GP was aware of the referral to Children's Social Care as this had been discussed between GP and the Midwife and this information should have been shared but not all professionals were consulted in the assessment process and had this been the case the information about Mother shaking baby Lydia and her drinking may have been disclosed to other professionals. The fact that Mother's behaviour at Lydia's birth over 4 years earlier had been recalled by the midwives first referral as being so unusual that it triggered the referral to Children's Services was significant in itself. This was not adequately taken into consideration by Children's Services. Mother's assertion that she required no additional support was accepted too readily.

Key Practice Episode 5: from August 2014

8.35. Kirsty was born on 25th June 2014. There are no indications that there were difficulties with the delivery and the family returned home with the usual level of support from universal services.

8.36. On 12th August 2014 Father contacted the health visitor to cancel the home visit arranged for that day as the family intended to go shopping. A new appointment was made for the following day. That same day Mother attended the GP's surgery with Kirsty for the 6 week check. Mother reported that all was going well. The GP noticed that Kirsty had 2 small bruises on her left cheek and a mark on her abdomen. Mother explained that these had been caused when Kirsty fell out of bed whilst asleep with Father and may have rolled out of bed. The GP accepted this explanation as being plausible. It should be noted that this was also a missed opportunity to challenge the family regarding co-sleeping.

8.37. On 13th August 2014, the following day, the health visitor conducted the home visit and noticed the two bruises on Kirsty's cheek. Father reported that the injury had been caused the previous Friday, the 8th August, when Kirsty rolled out of the bed. He expressed his view that Kirsty must have bumped her face on something. The parent's said that this had been seen by the GP the previous day but that they had not sought medical attention at the time of the incident. The health visitor insisted that this must be checked and directed that the parents must take Kirsty to hospital to see a paediatrician. Children's Services were then alerted to the presence of the injury and the health visitor made the parents aware that a referral had been made. Children's Services made the appropriate arrangements with the hospital for Kirsty to be examined by a paediatrician. The health visitor was unable to speak with the GP to seek to corroborate the parent's account as the GP was not in work that day.

8.38. The family were contacted by a social worker and asked to take Kirsty to the Hospital at 5.45pm that evening. Father said that were currently out and the earliest they could get to the hospital would be 7.10pm due to transport difficulties. The parents were advised that an overnight admission may be required and duly arrived at the hospital at 7.15pm were they were met by a social worker. Following the health visitor leaving the address to their arrival at hospital the parent's had unsupervised contact with Kirsty.

8.39. A paediatric assessment was conducted by the duty registrar paediatrician and a decision was taken for a full skeletal survey to take place the following morning and that Kirsty would remain on the ward overnight. Mother's behaviour deteriorated at this time, she pulled her hair and struck herself in the face. Hospital security were alerted due to her violent outburst and behaviour, However, Father was able to calm her down and as a consequence she was not removed from the hospital. The duty social worker recorded that Mother was very defensive and argumentative and accused Children's Services of wanting to take her babies from her.

8.40. Kirsty's father remained with her on the ward overnight. Routine nursing observations were made of Father's care and interaction with Kirsty overnight, as detailed in nursing records. It was documented by the nursing staff that when they questioned the social worker about supervision arrangements overnight they were told that no supervision was required of parents. This represented a potential risk to Kirsty, she was still in the process of having a full assessment as a result of her sustaining an injury and professionals had witnessed Mother being violent and aggressive. At the Learning Event professionals highlighted that continuous supervision of parents is not possible on a ward, nursing staff would always take guidance from the social worker around supervision arrangements. If supervision is required this should

be arranged by Children's Services to select a suitable family member or an approved carer. Children's Services can supply agency staff but there is not currently in place formal commissioning arrangements or a policy to give staff clear guidance on the formulation of an appropriate supervision plan.

8.41. On 14th August 2014, the skeletal survey and CT head scan were undertaken. This revealed that Kirsty had 10 fractures, of different ages. The findings included posterior rib fractures and metaphyseal fractures, which are highly suggestive of non-accidental injuries. The paediatrician noted that when the findings of Kirsty's examination were shared with the parents they did not show concern for her. Father immediately took the blame for the injuries demonstrating movements that he stated could have accidentally caused them. However, it was the paediatrician's professional assessment that the injuries were deliberately inflicted.

8.42. The police were notified of the outcome of the examination and both parents were arrested. A Police Protection Order was put in place for Kirsty and Lydia and both children were placed into foster care by Children's Services. Subsequently a decision was made by the paediatrician that a skeletal survey of Lydia would be unlikely to show any fractures she may have sustained in her very early years as they would have healed.

8.43. This is a Key Practice Episode as it details the opportunity that was lost when the GP saw the bruises on Kirsty's cheek but accepted the parent's account that they were caused accidentally. It also highlights the good practice undertaken by the health visitor in alerting Children's Services to the injury and refusing to be swayed by the parent's account of how the injury had occurred. The health visitor managed a potentially confrontational situation well by keeping Mother calm and averting a violent outburst. However, the plan to safeguard Kirsty after the health visitor made the referral to the time that Kirsty was presented at hospital did mean that the parent's had unsupervised contact with her after the concern had been raised. The overnight plan also lacked robust supervision of the parents. Father stayed on the ward with Kirsty with only informal observation from the nurses as advised from Children's Social Care. Lydia would therefore have potentially had unsupervised access from Mother.

9. Analysis by Theme

9.1. From the information extrapolated from the agency reports, from the discussions at the Learning Event, and from the meeting with the parents several key themes have emerged. These can be summarised as:

- The quality of assessments
- Quality of referral information
- The significance of gaps between referrals and dilution of concerns
- Existing child protection processes
- Impact on professionals and focus on Mother
- Think child
- Disengagement from services
- Communication, sharing and recording of information
- Injuries in non-mobile babies

- Domestic abuse

Viewed from a systemic perspective it is apparent how these themes influenced and impacted on each other and led to the circumstances which are the reason for this review.

The quality of the assessments

9.2. Working Together to Safeguard Children (DfE 2013) states; 'Information sharing between professionals and local agencies is essential for effective identification, assessment and service provision'. This review has identified that professionals considered the primary cause for concern for the safety of Kirsty and, prior to that, Lydia was the volatile mental health of their Mother. A reasonable conclusion to be drawn from this position would be that assessments of the capacity of parents to care for the children or of the potential harm they may present to the children would clearly benefit from the input of the professionals who had engaged most closely with them. At the Learning Event there was a discussion about the threshold for a child protection conference in 2010. It was acknowledged that it was local practice to convene a conference when professionals thought a plan was needed, rather than getting the agencies around the table to secure a better assessment of the risk and then consider together the need for a child protection plan. The low proportion of conferences that did not result in a child protection plan at the time supports this approach.

9.3. The initial strategy meeting that was convened following the birth of Lydia was relatively well represented by professionals. However, missing from the meeting was the GP, who had known Mother for several years. Moreover, the psychiatrist who had conducted the mental health assessment of Mother only the day before was not invited to the meeting. It is recognised that strategy meetings are usually held at short notice and clinicians will find it difficult to attend. The GP did feed in some information to assist in the assessment but was clearly not able to participate in discussions around the impact that Lydia's birth had had on Mother's mental health. The duty psychiatrist had formed the opinion that Mother did not show any significant mental health problems, for example a perinatal psychosis, yet an option was constructed around the possibility of Mother being admitted into the local psychiatric hospital. It is likely that had the psychiatrist been present at the strategy meeting to explain the reasoning behind their assessment findings that Mother did not have a mental health disorder that this would not have been pursued as an option and this was reiterated at the Learning Event. Without this option on the table there may have been a more robust consideration of the remaining option of Lydia going home with Mother and Father and whether this plan was appropriate.

9.4. Considerable weight was placed on the belief that Father was a protective factor. This belief was informed by information from the GP who was describing how Father was protective of Mother and would 'do anything for her'. This was reinforced following meetings with Paternal and Maternal Grandparents, who were also part of the safety plan. Father is described as' doting' on Mother and was seen to be effective at calming her down during one of her outbursts. What it was not possible to assess at this early stage was whether Father would extend his protective character to their baby. However, the plan that was implemented rested heavily on Father's capacity to effectively care for Lydia, and to put his child's safety before his partner if necessary. In any case, during the lead reviewer's meeting with Father he said that he had not been made aware of his primary role as Lydia's carer.

9.5. At the Learning Event some professionals agreed that the initial assessment of the family undertaken in 2010 following the birth of baby Lydia did not have sufficient depth. The final

core assessment was not written up until October 2010, six months after the initial referral. The chronology report submitted by the Children's Services agency report author concludes that the assessment was very brief and did not give adequate emphasis to the risks Mother may pose.

9.6. The brief assessment of the family conducted by Children's Services in May 2014, prior to Kirsty's birth, followed a similar pattern. The author of the Health Trust agency report acknowledges that the referral from the midwives contained little information. Written information available from the strategy meeting and the conclusion of Section 47 was not shared with midwives which reduced the amount of information they could provide in the referral. The Midwife who made the referral has outlined how little information was available to her. As a consequence the full impact of the behaviour of the Mother on the ward immediately after Lydia's birth was not contained in the referral. The constant factor in the family over the 4 year period between the birth of Lydia and this new referral was the GP, who was consulted by the community midwife about the referral. However, the GP's input was not sought as part of the assessment following the referral. A CAF[3] was not submitted, nor was a MAF[4] put in place. This poor feed of information into the referral and subsequent assessment resulted in the potentially key information relating to Mother admitting she had shaken baby Lydia, the two Accident and Emergency visits where Lydia had injuries, and the concerns about Mother's excessive drinking being missed in the assessment process.

9.7. A key voice that wasn't heard as part of the assessment process following the referral in May 2014 was Lydia's. Although only 4 years of age she may have been able to give a valuable insight into the experience of growing up in this family environment. As one professional said at the Learning Event, "Think family should read think child". Lydia's lived experience was missing from the consideration given to the information available about the family at this time.

9.8. The author of the primary care agency report makes reference to the lack of coding of key life events for the Mother in her GP records. Mother was clearly a very frequent visitor to the surgery and it was positive that the GP had made several referrals to mental health services to support her. What was acknowledged as missing was a chronology of life events and the impact that they had on Mother's wellbeing. As the author outlines, if the life events were computer coded the Mother's profile would have looked different and perhaps different support offered. Not only would such a chronology assist in the referral to different support networks, it would have been a useful tool in the assessment process. It would also have alerted the GP to a number of missed appointments. This is echoed by the author of the Children's Services agency report who outlines that the lack of a chronology of events and outcomes following the birth of Lydia made the gathering of information to assess any potential risk to the expected baby (Kirsty) a much more difficult task. The social workers needed to read a large number of case notes and minutes of meetings to gain an understanding and make an assessment of what had taken place before.

9.9. **Lessons Learned**:

- It is important that the professionals who possess the key information about the

[3] CAF - Common Assessment Framework

[4] MAF – Maternity Assessment Framework

family, including the parents, are involved in the referral and assessment process.

- Where a child can give an insight into their experience of living in a family it is important that the child's voice is heard as part of the assessment.
- The chronological recording of key life events as recorded during contact with professionals is a valuable tool in determining appropriate support and to facilitate effective cross referencing of records with other agencies as part of an assessment process.

Quality of referral information

9.10. The initial referral made by the midwives following their observation of Mother's behaviour contained a detailed account of what happened and their concerns that Mother could present a serious risk of harm to Lydia. The level of detail was such that it triggered a rapid response from Children's Services to undertake a child protection investigation.

9.11. The second referral that was made in respect of the family by the community midwives lacked detail and used language that resulted in the minimization of the threat posed by Mother. At the Recall Event midwives explained that they had very limited information to feed into the referral and that the report was made as a result of them recollecting how Mother had behaved during the first birth. The word 'tantrum' was used which failed to capture the extreme behaviour displayed by Mother that had been described so clearly in the first referral and assessment. At the time of this referral a number of agencies did possess information that showed that Mother had admitted to shaking Lydia whilst in hospital; that Lydia had attended Accident and Emergency on two occasions (albeit on their own this was not significant or concerning); that Mother had been violent towards Father; that Mother had experienced a bereavement that had impacted upon her depression, that Mother was struggling with the care of Lydia on occasion, and that Mother had reported to have been drinking heavily. Consequently, this is a lost opportunity to re-assess the family and the risk posed not only to the expected child, but also to Lydia. It was accepted that Children's Services had not been provided with any further information from March 2010, which was taken to mean that there had been no concerns between the first and second referral.

9.12. The final referral was made by the health visitor who noticed the bruises on Kirsty's cheek. Notwithstanding that the Mother and Father sought to explain how the bruise had been caused and that the injury had been seen by the GP, the health visitor followed the revised local policy in relation to bruising to non-mobile babies and made the referral.

9.13. **Lessons Learned**

- Professionals who are making referrals should consider whether additional information may be available from other agencies, including adults services, to inform the referral which requests an assessment of the risk posed to the child.
- Professionals should review the thresholds document when making referrals to guide them to highlight areas of concern.

The significance of gaps between referrals and dilution of concerns

9.14. At the Learning Event there was discussion about the inference that professionals could draw on a significant time gap between the referrals. It has already been highlighted that the language used in the second referral had the effect of minimising the Mother's

behaviour at the time of Lydia's birth. Moreover, the fact that information was not sought from other key agencies created the appearance that there had been no incidents of concern that had occurred in the intervening 4 years.

9.15. This minimisation of Mother's behaviour in the referral, taken with the apparent lack of evidence that her subsequent behaviour had created a cause for concern, had the potential to reassure professionals that Mother had settled well and presented no risk of harm to the expected child. In fact there had been a number of concerns recorded across agencies, but not shared effectively.

9.16. Reference has already been made to the difficulties experienced by the social workers in accessing information in relation to the events that followed the birth of baby Lydia. The telephone conversation with Mother sought to reassure the social worker that things had moved on positively following Lydia's birth. The absence of a chronology and a lack of detail of issues that had occurred in the intervening period added weight to the assessment that there was no further action required from Children's Services. In effect, the gap between the referrals and the absence of information to indicate that Mother may not have moved on, as shown by a number of concerning events, acted as reassurance to the assessing social worker that there were no concerns. To rely on self-reporting from parents is rarely appropriate. Full agency checks should be undertaken, particularly when there has been a history of mental health issues.

9.17. **Lessons learned**:

- Professionals assessing risk should be curious about gaps in referral history. They should be seen as a trigger to question and challenge rather than providing reassurance that there is an absence of risk.

Child protection processes in 2010

9.18. It is reported that in 2010 the coordination of Early Help Services was still developing, although child protection processes have not changed. Reference was made in the Children's Services agency report that this could have been considered as an option following the closure of the core assessment in October 2010. This would have required the step down to a CAF, enabling professionals to embark on a more sustained piece of work with the parents and Lydia. This would be through an Early Help Assessment. However, given that the service was in its infancy at the time it is understandable that the decision was taken to refer back to universal provision.

9.19. When Lydia was seen in Accident and Emergency with bruising to the left side of her face and arm in 2010, Father reported having fallen with her in his arms. Bruising has always been considered suspicious in a non-mobile infant. However, at that time the Health Trust policy gave practitioners the flexibility to assess the reason given and the credibility of the explanation whilst also considering the developmental stage of the child. In this case the explanation given to staff was felt to be plausible and there was no concern or referral made to Children's Services. This was in accordance with Trust and multi-agency guidance at the time. The guidance stated that if there was a credible witnessed account for the injury and the circumstances were reviewed by the senior doctor in Accident and Emergency, then a safeguarding referral need not be made.

9.20. The Health Trust agency report outlines that the health visitors would have received a copy of the Accident and Emergency attendance report. However, the health visitors were aware of the Trust policy that was in place at that time and accepted that the injury was

accidental. The guidelines in place at that time relating to when a home visit should be conducted were considered and the health visitor considered that a follow up telephone call to Mother was the appropriate course of action. In this conversation the health visitor discussed the mechanism of the accident with Mother and advised on safety in the home which was good practice.

9.21. The Primary Care agency report details that Supporting Families meetings[5] were put in place for GPs from November 2010. This was after the initial referral and core assessment that followed Lydia's birth. However, the author of the agency report suggests that the GP did not see the family as presenting a problem and may not in any case have put them forward for discussion at a Supporting Families meeting.

9.22. **Lessons Learned**:

- Procedural changes and the development and improved coordination of the Early Help Service ensure that professionals have improved tools to support families at risk.
- The early implementation of the Supporting Families meetings at GP surgeries is positive. It is important that GPs take advantage of the meeting review records and share crucial information and are aware of what the Early Help Service can offer.

Impact on Professionals

9.23. The primary service that engaged with the family throughout the duration of the scoping period of this review was health. The GP, community midwives, health visitors and community psychiatric nurses all formed supportive relationships with the family. Whilst Father was registered with a different GP practice, he did make regular contact with Mother's GP to share his concerns and seek support for his wife.

9.24. The length and consistency of the relationship between the Mother and her GP is seen as a positive factor. The GP had frequent contact with Mother and made several referrals to mental health services to support her. Understandably there was a focus on the Mother's health and wellbeing given the frequency of the contact with the GP. It is not questioned that Mother had endured a traumatic childhood and the life events that followed had a heavy impact on her mental wellbeing. Episodes of self-harm, suicide ideation and low mood were significant issues for her GP to support her through. The additional stresses from bereavement were substantial triggers to her underlying vulnerability. In the primary care agency report the author outlines that GPs are trained to believe the word of their patients. Clearly Mother had shared many personal experiences and feelings with her GP over the many consultations she had attended. This created a situation where the GP took self-reporting by the Mother on face value. For example, when Mother disclosed that she had been drinking two bottles of wine a day but was now abstinent this was seen as being true, notwithstanding that the liver function tests contradicted this. Although it is acknowledged that the results of the liver function tests could also be caused by a gall bladder problem, there was a need for the impact of the level of alcohol consumption to be considered more critically, and that the inherent impact on Mother's capacity to care for her child was fully considered.

[5] Supporting Families Meetings are chaired by GPs and involve other professionals from universal health services to discuss families that are identified as having complex needs.

9.25. Professionals engaged with the family formed a collective view that the Father and wider family were protective factors. Stabilising Mother's volatile mood swings was seen as the key priority in creating a safe family unit. It is therefore not surprising that the focus of the professionals' attention centred on Mother and there was optimism that her mood swings could be managed. As someone who called upon the health service on a frequent basis Mother was very capable of ensuring that her voice was heard. It is noted that on reflection the GP considers that she was 'played' by Mother. It is the author's view that Mother sought to manipulate the other professionals she was in contact with and she had become skilled in telling professionals what she thought they wanted to hear. This resulted in the shifting of attention onto the Mother and away from other members of the family. Even Father reported to the lead reviewer that he often had to miss work in order to accompany Mother to medical appointments.

9.26. Self-reporting appears as a consistent theme through the review. Examples of this include:

- The disclosure to the community psychiatric nurse by Mother that she had shaken Lydia but that this had been investigated by Children's Services was taken as a true account.
- The account the parents provided at hospital to explain the bruising on Lydia's cheek was taken as plausible.
- The acceptance by the GP that Mother was abstinent from alcohol.
- The referral in May 2014 resulted in a telephone call being made to Mother by the social worker. Her account of the current family situation was not cross-referenced by speaking to other family members or professionals.
- The explanation given to the GP to account for the bruising on Kirsty's cheek was thought to be plausible.

The limited professional curiosity and the absence of tenacity to check out claims contributed to over optimism and opportunities to check the hypothesis being missed.

9.27. **Lessons Learned:**

- Relationships between GPs and their patients must be formed on a bond of trust. However, when the patient is part of a family unit, and specifically when a new born or young child is a member of that family, then it is important for the GP to see beyond the needs of the patient alone.
- Self-reporting is a valid way in which professionals acquire information. Where concerns have been raised that indicate that there is a potential risk of harm to a child then professionals must employ their 'professional curiosity' to seek to cross-reference and corroborate what they are being told.
- Over optimism among some of the professionals who engaged with the family led to the view that Mother had the capacity and motivation to provide the quality of the care that the children required. Professionals must challenge their views and test their perceptions against other sources of information.
- GPs often work in environments where there is no supervision or peer-to-peer challenge of the decisions they make. They should be encouraged to create an environment where they can step-back from the decisions they have taken and review them with greater objectivity, for example by way of peer review.

Think Child

9.28. As was reported in paragraph 9.7, the phrase **"t**hink family should read think child**"** was stated at the Learning Event. At the initial referral to Children**'**s Services a good assessment of the wider family's capability to support the parents was undertaken. As has already been reported, Father was seen as a protective factor. However, the fact that he may place the protection of Mother over the protection of baby Lydia, and an understanding of the dynamics of the couple's relationship was not recorded as being considered.

9.29. Several opportunities to reassess the potential risk posed by Mother to Lydia were missed. The disclosure to the community psychiatric nurse by Mother that she could not cope and that she had shaken Lydia was not acted upon because the professional believed Mother**'**s account that this had already been investigated. The first presentation to Accident and Emergency with Lydia was again an example of professionals taking the account of the parents, albeit plausible, as true explanations for the causes of Lydia**'**s injuries. The significance of the disclosure to the GP and the CPN of a considerable increase in the use of alcohol by Mother was not seen as a safeguarding risk as Mother outlined that she was now abstinent. Liver function tests made Mother**'**s claim of abstinence questionable, but the issue was seen more of a health problem for Mother than a potential risk of harm for Lydia.

9.30. At the time of the second referral to Children**'**s Services in May 2014, Lydia was over 4 years old and would therefore be able to describe her experiences in the family home, if asked in a skilful way by someone used to talking to children. However, the assessment undertaken by the social worker was limited to a telephone call to Mother. The opportunity to hear from Father, Paternal Grandparents, and Maternal Grandfather was missed. More significantly so was the opportunity to hear from the one person who knew what it was like to be a child in the household.

9.31. Following the third referral from the health visitor, the parents were required to make their own arrangements to transport Kirsty to hospital and make child care arrangements for Lydia. This in effect left them with unsupervised contact with the children for a considerable period of time. This immediately followed an assessment by a professional that Kirsty was potentially at risk of harm from her parents. Given that it was known that Mother was prone to violent outbursts when under duress this was a concerning exposure of risk to the children. Moreover, once the extent of the injuries to Kirsty had been established and the decision was taken to take both children into care it took agencies some time to locate Lydia. The gaps in the planning around this are a cause for concern. At the Learning Event it was established that the health visitor did not have a mobile phone with her and this caused some logistical problems around making arrangements. It was apparent that due process was being considered but immediate concern for the welfare of the children at that time seemed to be absent from the decision making.

9.32. **Lessons Learned:**

- When parents have complex emotional and mental health problems, professionals should always consider the impact on the children, including challenging parents as required.

- Where there is evidence of the toxic trio being present, as was potentially the case here, the impact of this on children in a household should be foremost in the consideration of professionals[6].
- Where social workers are conducting an assessment following a referral and there is a child's voice that can be heard as part of that assessment process, it is imperative that that voice is heard. Observing and describing the children is not the same as working directly with them, speaking to them, and ensuring their voices are heard, recorded, and make a difference.
- When a professional recognises that there is an apparent risk of physical harm to a child from the parents and that this risk is such that it requires a referral to Children's Services for assessment and investigation, immediate steps should be taken to safeguard the child from further risk while the processes are followed.
- When a parent informs a professional that a serious child protection concern has been reported in the past and has been subject of an investigation, this claim should be checked with other agencies.

Disengagement from services

9.33. There is no doubt that Mother's health needs were complex or that she was proactive in seeking support from her GP. The nature of her mental health issues made them a problem for which there was not an easy solution. The psychiatrist's assessment of Mother soon after the birth of Lydia indicated that there was no significant mental health illness. Had there been a significant problem this, ironically, may have been easier to manage. Instead Mother followed a repeat pattern of experiencing a crisis, seeking help, obtaining a referral and then disengaging from services.

9.34. To make resolution of issues even more complex, Mother was not compelled to consistently access psychiatric support. For example, when doctor on duty referred her for mental health support during the second trimester of her pregnancy with Kirsty she attended the initial appointment but did not attend her second appointment and was subsequently discharged.

9.35. There was an element of confusion in relation to the appropriate service that Mother should be referred to. The referral made by the doctor on duty when Mother was pregnant with Kirsty was made to health psychology. This was inappropriate; the referral should have been made to perinatal psychiatry. It has already been identified as good practice that health psychology recognised this and rather than referring back to the ward, the perinatal psychiatry team received the referral through inter-service communication. Notwithstanding this good practice, Mother duly failed to attend the appointment and was discharged from psychiatry.

9.36. The revolving door nature of Mother's access to services, taken with her regular approaches to the GP for support, had the effect of disguising the depth of the issues that she was facing. For example, in 2011 Mother wrote to her GP describing graphically the depth of her feelings, her self-harm, suicide ideation and the impact of being with her adoptive mother when she passed away. The author of the primary care agency report rightly identi-

[6] Cleaver, Unell and Aldgate (2011) - Children's Needs - Parenting Capacity

fies that these are not the words of a person experiencing a low mood, but a significant cry for help. Moreover, the content of the letter was such that consideration should have been given to the impact that her mental health would have had on her family.

9.37. There was evidence of Mother picking and choosing which appointments she would attend. A concerning example of this was when her GP received the letter from the psychiatrist detailing that Mother had disclosed she had shaken Lydia. The GP contacted Mother to advise that she should make an appointment to discuss the letter. Mother did not make an appointment and the content of the letter was not further discussed.

9.38. It is possible that Mother only sought to engage with services when she considered it was in her interest. 'Disguised compliance' is a term that can be attributed to Reder, Duncan and Gray[7]. In involved a parent or carer giving the appearance of co-operating with agencies to avoid raising suspicions, to allay professional concerns, and ultimately to diffuse professional intervention. It was apparent at the Learning Event that a number of professionals had formed the view that Mother was adept at saying the right things to the right agencies. When she was robustly challenged or events weren't going as she wanted, it was well reported that a violent tantrum would often follow. The significance of this when she was caring for two young children was not considered.

9.39. **Lessons Learned:**

- Where a parent chooses not to engage with services, and this may have an impact on their capacity to parent, a process should be in place to ensure the referring agency is informed.
- Professionals need to be aware that disguised compliance may be used by parents to avoid engaging in a meaningful way. Where a patient or parent is saying the right thing but there is some evidence to indicate a lack of compliance then this should be challenged by professionals.
- Professionals who hold responsibility for making referrals should ensure that they have clarity on the appropriate pathways to make those referrals and they are fully aware of the services that are available.

Communication, sharing and recording information

9.40. It was apparent in the Learning Event that different agencies tended to rely on different methods to communicate information initially. Health professionals tended to rely almost exclusively on letters or writing whilst Children's Services and police prefer the spoken word. These preferred or usual methods of communication resulted in confusion arising and some agencies being unclear on the outcome of assessments or the detail of plans. For example, in the Foundation Trust agency report concern was registered that there was no written outcome of the Section 47 enquiry that followed the first referral to Children's Services. In addition, during this period, there was no written report of the psychiatric assessment of mother provided to Children's Services.

9.41. The confusion arising from a lack of clarity in communication was also reported by the parents to the lead reviewer. Mother stated that her concerns immediately following Lydia's

[7] Peter Reder, Sylvia Duncan and Moira Gray in 'Beyond blame: child abuse tragedies revisited' (1993).

birth were not taken seriously and she did not receive clear information regarding what she was likely to experience following child birth. Father outlined that he was not aware that there was a plan in place around Lydia and that he had a primary role in that plan. Both parents, although interviewed separately, outlined that an out of GP hours contact number for services would have been helpful.

9.42. The referral made by the hospital midwives to Children's Services regarding Lydia is praised for the level of detail that it contained. The language was persuasive and presented a clear picture of the violent behaviour that Mother was displaying on the ward. This was a stark contrast to the second referral that was made prior to Kirsty's birth regarding the historic concerns. The word 'tantrum' was used and the overall tone tended to minimise Mother's behaviour and consequently dilute the concerns in relation to the risk of harm she may present to her new born baby.

9.43. Lydia's first presentation to Accident and Emergency with facial bruises has already been identified as a potential opportunity to reassess the family. Staff adhered to the policy that was in place at that time. This policy has now been revised and for any immobile baby seen in Accident and Emergency with bruising a referral to Children's Services would be made. The GP was notified of the hospital attendance but the potential significance of the injury was overlooked, predominantly as the explanation that it was caused by Father falling with Lydia in his arms was accepted as plausible. Moreover, this information was not sought or shared when the assessment of the family was undertaken following the second referral to Children's Services after the birth of Kirsty. It was not until the final referral following the notification of Kirsty's injuries that this information was shared with Children's Services. As no holistic investigation was undertaken in regard to Lydia's injuries at the time, it cannot be ascertained how likely it is that they were accidental.

9.44. The Primary Care agency report details the opportunities that were lost due to significant events in Mother's history not being effectively coded and recorded in her health records. The author makes the observation that had the life events been coded this may have resulted in different support being offered to Mother. The report also expresses concern that the GP was not invited to contribute to the assessment at the time of the second referral. A valid point is made that had the GP been aware of other agency concerns about a risk that Mother may present to her new born baby, she may have been more challenging about the explanation that Kirsty's parents gave for the bruising on her cheek.

9.45. The Health Trust agency report outlines that there was a lack of detail in the minutes of the strategy meeting held following Lydia's birth. This caused confusion around what was included in the plan and the expectations of the different agencies. No strategy minutes were distributed to agencies involved and no information of the Section 47 was received. This lack of detail extended to the Section 47 investigation where no detail of the outcome is recorded in health case notes. Given that the primary cause for the referral to Children's Services was concern about Mother's mental health it is concerning that there is no record of the investigation in health case notes.

9.46. **Lessons Learned:**

- Professionals should carefully choose the language they use when making referrals to avoid misinterpretation or the dilution of concerns. The language used in the first referral was graphic as it contained evidence of what the midwives had observed of Mother's behaviour.

- Communication channels must be made open to all professionals engaging with a family when a concern is raised and an assessment is undertaken. The presence of a professional at the table, for example at a strategy meeting, minimises the risk of mis-interpretation of the information they possess.
- The effective recording and coding of significant events that impact on a patient's mental health and well being serve as useful tools in understanding the whole picture around the patient. They provide useful information when preparing chronologies that allows effective cross-referencing of information between agencies.
- Professionals should have clarity in their expectations and use clear language about why they have made a referral to an agency and what is expected of the agency receiving the referral.
- The parents reported difficulty in understanding how to access health advice when the GP was not available to them. Notwithstanding that useful numbers are provided to new parents, the Health Trust should consider providing 'contact cards' with key numbers for new parents.

Injuries in non-mobile babies

9.47. The Health Trust local policy in 2010 allowed for professional judgement in regards to bruising in infants. Where parents were able to account for the presence of an injury with a plausible explanation, and there were no other concerns known, this would negate the requirement for further investigation. This was clearly the case when Lydia was presented to Accident and Emergency in July 2010. Hospital staff and health visitors considered the injuries as accidental and applied the policy and as a consequence a referral was not made. The acceptance of the account from one professional seemed to act as a signal to allay the concerns of other professionals who became aware of the injury to Lydia. There was a lack of respectful professional challenge, and the conclusion of the professional undertaking the medical examination was accepted by the other professionals. It is noted that the Health Visitor followed up the incident with the parents which indicated good communication.

9.48. The change in the policy and its implementation in practice was adopted following the excellent practice of the health visitor who saw Kirsty's bruises. Notwithstanding that the parents offered an explanation and outlined that the bruises had been seen by the GP as part of the 6 week check, the health visitor tenaciously insisted that the injuries should be properly assessed. This assessment uncovered Kirsty's significant injuries.

9.49. The Primary Care agency report details the author's surprise that the GP who examined Kirsty at the 6 week check did not 'think the unthinkable' and consider that the injury could be non-accidental. An explanation is offered for how this may have arisen, with Father stating that Kirsty had rolled off their bed. More significantly, the author has highlighted that there is now a change in local policy for GP's that mirrors that of the Health Trust. This policy has been disseminated to all surgeries in the NSCB area and is embedded in training for GPs. This has had the effect of lowering the thresholds at which GPs will refer babies to Children's Services.

9.50. In 2009 the NSPCC published a review of worldwide research into bruising in children. It highlighted several key messages including:

- 'Bruising is strongly related to mobility
- Accidental bruising in children who have no independent mobility is very unusual
- Only one in five children who are starting to walk by holding onto furniture has bruises
- It is common to have fractures (particularly rib) without any bruising
- The head is by far the commonest site of bruising in child abuse, as are the ears and neck.

9.51. Ofsted reports summarising the learning from SCRs have consistently highlighted that babies of less than one year have been the subject of a high proportion of reviews. In the report 'Ages of Concern: Learning Lessons from Serious Case Reviews', Ofsted published a thematic report of their evaluation of serious case reviews from 1 April 2007 to 31 March 2011 including specific learning gained from the deaths of babies under one. It shows that 35% of child deaths are in this age group.

9.52. **Lessons Learned:**

- Professionals should suspect abuse when faced with bruising in a non-mobile baby. Even though a parent may be able to offer a plausible explanation for how an injury has occurred the fact that an infant who clearly does not have the mobility to injure themselves must be referred to Children's Services.
- Supervision of family contact during an on-going child protection investigation is very important in preventing further harm to the child. The safety of siblings must also be considered during the investigation.

Domestic Abuse

9.53. During the child protection investigation following the birth of Lydia, Mother disclosed to a social worker that she had hit Father, although the she said that the incident shocked her so much there had not been a repeat of it. The significance of this disclosure was not recognised by professionals and it was discussed at the Recall Event what action would have been taken had the Father made a similar disclosure. The presence of violence within a household and the impact it has on the children living there must be considered fully by professionals, whether the perpetrator of the violence is male or female.

9.54. Father was known to have contacted Mother's GP on a number of occasions expressing concern about her drinking and her behaviour when in a low mood. This was consistently seen as Father being supportive of Mother and seeking to commission help for her. Consideration was not given to the fact that he may have been seeking help to protect himself, nor to the fact that Lydia was growing up in an environment where she was potentially consistently witnessing violent and aggressive behaviour. When the lead reviewer met with Father he asked if on hindsight he wished he had sought more support for the family. Even with the benefit of such hindsight Father appeared reluctant to acknowledge that help was required.

9.55. There was significant evidence of Mother's capacity to harm herself. This ranged from self-reported suicide ideation and self-harm to witnessed violent outbursts where Mother would strike herself, particularly if she was not getting her own way or felt that she was being chal-

lenged. The impact of the children being exposed to this behaviour was not fully considered.

9.56. **Lessons Learned:**

- Professionals should guard against gender bias and see the harm posed to a child by violence in the household, whether the perpetrator of the violence be male or female or whether the violence is directed to another or is a form of self-harm. Much work has been done to develop a better understanding of domestic violence and to better define it. Professionals should guard against the temptation to define what is reported to them at the expense of missing the impact of the violence.

Good Practice

9.57. There were a number of examples identified in this case of good practice across all the agencies involved. Whilst some of these examples reflect expected standards it is nonetheless important that this positive work is highlighted. Examples include:

- A good quality of information contained in the initial referral from the hospital midwives.
- Good attendance from a number of agencies who were invited to the initial strategy meeting.
- Continuity of care and support from the GP to Mother and the multiple referrals the GP made to mental health services.
- The referral of Mother to the high risk clinic by midwives in both pregnancies.
- The internal transfer of the referral from health psychology to perinatal psychiatry.
- The application of the revised policy relating to injuries to non-mobile babies and the tenacity of the health visitor in making the referral.
- The speed at which the initial assessment was undertaken and the rigour in which procedures were implemented following the third referral and the speed that the fractures were identified.
- The effectiveness of the communication between day time services and the Emergency Duty Team with clarity around contingencies in the event that the parents may choose to act in a way to jeopardise the safety of Kirsty.
- There was clear adherence to the procedure for a multi-agency strategy meeting with the emphasis on key information directly available from the paediatrician and appropriate early involvement of the police.
- The safeguarding plans for Kirsty and Lydia recognised that there was a potential for wider family to be implicated when explanations for injuries were not satisfactory and resulted in safe foster placements.
- The involvement with Kirsty saw early consultation with the Local Authority solicitor with immediate steps taken to ensure that both children were safeguarded through care proceedings and accommodation.

10. Conclusions

10.1. This review has sought to establish whether the circumstances in which Kirsty was harmed were preventable. A number of missed opportunities to assess the harm posed to Kirsty and Lydia by the parents were identified as part of the review process. It is hoped that the learning from this review will alert all professionals in Northumberland, and beyond, to the potential for children to be harmed by parents experiencing complex emotional problems.

10.2. The review has attempted to avoid hindsight bias which "oversimplifies or trivialises the situation confronting the practitioner and masks the processes affecting practitioner behaviour" (Woods et al[8]). It has identified the following learning points which have been outlined above:

- It is important that the professionals who possess the key information about the family are involved in the referral and assessment process.
- Where a child can give an insight into the experience of living in a family that is subject of an assessment it is important that the child's voice is heard.
- The chronological recording of key life events is a valuable tool in determining appropriate support and to facilitate effective cross referencing of records with other agencies as part of an assessment process.
- Professionals who are making referrals should consider whether additional information may be available from other agencies, including adult services, to inform the referral which requests an assessment of the risk posed to the child.
- Professionals should review the thresholds document when making referrals to guide them to highlight areas of concern.
- Professionals assessing risk should be curious about gaps in referral history. They should be seen as a trigger to question and challenge rather than providing reassurance that there is an absence of risk.
- Procedural changes and the introduction of the Early Help Service have given professionals improved tools to support families at risk.
- The early implementation of the Supporting Families meetings at GP surgeries is positive. It is important that GPs take advantage of the meeting review records and share crucial information and are aware of what the Early Help Service can offer.
- Relationships between GPs and their patients must be formed on a bond of trust. However, when the patient is part of a family unit and specifically when a new born or young child is a member of that family, then it is important for the GP to see beyond the needs of the patient alone.
- Self-reporting is a valid way in which professionals acquire information. Where concerns have been raised that indicate that there is a potential risk of harm to a child then professionals must employ a 'professional curiosity' to seek to cross-reference or corroborate what they are being told.
- Over optimism among some of the professionals who engaged with the family led to the view that Mother had the capacity and motivation to provide the quality of the care that the children required. Professionals must challenge their views and test

[8] David D Woods et al. Behind Human Error. 2010.

their perceptions against other sources of information.

- GPs often work in environments where there is no supervision or peer-to-peer challenge of the decisions they make. They should be encouraged to create an environment where they can step-back from the decisions they have taken and review them with greater objectivity, for example by way of peer review.
- When parents have complex emotional and mental health problems, professionals should always consider the impact on the children, including challenging parents as required.
- Where there is evidence of the toxic trio being present, as was potentially the case here, the impact of this on children in a household should be foremost in the consideration of professionals.
- Where social workers are conducting an assessment following a referral and there is a child's voice that can be heard as part of that assessment process, it is imperative that that voice is heard. It is important to work directly with the children. Observing and describing the children is not the same as speaking to them and ensuring their voices are heard and recorded.
- When a professional recognises that there is an apparent risk of harm to a child from the parents and that this risk is such that it requires a referral to Children's Services for assessment and investigation, then immediate steps should be taken to safeguard the child from further risk while the processes are followed.
- When a parent informs a professional that a serious child protection concern has been reported in the past and has been subject of an investigation, this claim should be checked with other agencies.
- Where a parent chooses not to engage with services, and this may have an impact on their capacity to parent, a process should be in place to ensure the referring agency is informed.
- Professionals need to watch for disguised compliance from parents. Where a patient or parent is saying the right thing but there is some evidence to indicate a lack of compliance then this should be challenged by professionals.
- Professionals who hold responsibility for making referrals should ensure that they have clarity on the appropriate pathways to make those referrals and they are fully aware of the services that are available to them.
- Professionals should carefully choose the language they use when making referrals to avoid misinterpretation or the dilution of concerns. The language used in the first referral was graphic as it contained evidence of what the midwives had observed of Mother's behaviour.
- Communication channels must be made open to all professionals engaging with a family when a concern is raised and an assessment is undertaken. The presence of a professional at the table minimises the risk of misinterpretation of the information they possess.
- The effective recording and coding of significant events that impact a patient's mental health and well being serve as useful tools in understanding the whole picture around the patient. They provide useful information when preparing chronologies that allow effective cross-referencing of information between agencies.

- Professionals should have clarity in their expectations and use clear language about why they have made a referral to an agency and what is expected of the agency receiving the referral.
- The parents reported difficulty in understanding how to access health advice when the GP was not available to them. Notwithstanding that useful numbers are provided to new parents, the Health Trust should consider providing 'contact cards' with key numbers for new parents.
- Professionals should suspect abuse when faced with bruising in a non-mobile baby. Even though a parent may be able to offer a plausible explanation for how an injury has occurred the fact that an infant who clearly does not have the mobility to injure themselves must be referred to Children's Services.
- The local application of the revised policy in respect of injuries to non-mobile babies is worthy of reinforcement with the intervention of the health worker being cited as good practice.
- Supervision of family contact during an on-going child protection investigation is very important in preventing further harm to the child. The safety of siblings must also be considered during the investigation.
- Professionals should guard against gender bias and see the harm posed to a child by violence in the household, whether the perpetrator of the violence be male or female or whether the violence is directed to another or is a form of self-harm. Much work has been done to develop a better understanding of domestic violence and to better define it. Professionals should guard against the temptation to define what is reported to them at the expense of missing the impact of the violence.

10.3. Even without the benefit of hindsight there was evidence available that Mother or Father might pose a risk to children before the incident in August 2014. The initial Section 47 investigation failed to draw upon the extensive knowledge of Mother held by her GP. The disclosure by Mother that she had shaken Lydia is a significant piece of information that was a lost opportunity to intervene as health professionals took on face value Mother's account that this incident had already been investigated by Children's Services. The presentation of Lydia at Accident and Emergency by the parents with bruising on one occasion and an injured leg on another did present opportunities to reassess the risk that the parents posed, or to provide support to the family. It is recognised however that this arose from the application of the then policy where plausible accounts for injuries may be accepted when there has been senior oversight of the judgement of the professional without need for further investigation. The presence of a bruise on a non-mobile child would result in an automatic referral to Children's Services today, however the leg injury may still not be referred.

10.4. There were a number of opportunities that were missed to allow a reassessment of Mother's parenting capability and any risk posed to the children:

- The disclosure that Mother was drinking heavily but was now abstinent was taken on face value by health professionals despite the presence of conflicting evidence.
- The impact of the prolonged excessive drinking when taken with Mother's already volatile mood swings was not recognised as representing a potential risk to Lydia.
- The referral made by midwives during Mother's pregnancy with Kirsty did not act as a catalyst to undertake a more detailed assessment of the family. Had it done so,

the detail of the earlier events and their significance in safeguarding the children should have come to light.

- The acceptance by the GP that Kirsty's injuries had been caused accidentally notwithstanding the knowledge she had of the family and specifically Mother showed a degree of naivety and lack of awareness of the potential for non-accidental injury. Although Kirsty's injuries had already been inflicted at that stage, the decision exposed the children to the potential of further harm.

10.5. Both Lydia and Kirsty are likely to have experienced both emotional harm and physical abuse within their home. This would have been distressing and painful for them and potentially put their lives at risk. There were opportunities to safeguard them prior to the date where Kirsty's extensive injuries were identified. These were not taken.

10.6. A number of changes have taken place in Northumberland since the serious concerns about Kirsty emerged in August 2014. This reflects the fact that some of the "best learning from serious case reviews may come from the process of carrying out the review" [9]

- In the event of a non-mobile baby presenting with bruising, even though a plausible account for the injury may be forthcoming from the parents, all professionals, including GPs, will refer the family to Children's Services. This change in policy is now incorporated in training given to GPs and other professionals providing universal services.
- The Health Trust is committed to improving the quality of referrals made to Children's Services by community midwives to ensure that all available information is included in the referral. As a result of learning from this case community midwives have already been trained in making good quality referrals.
- There is a drive from GPs to increase attendance at the Supporting Families meetings.
- Where parents self-disclose information to mental health professionals that indicates an actual or potential risk to children the professional will report this to Children's Services.

11. Recommendations

11.1. It is recognised that actions have already been made in relation to some of the individual agency's identified learning. In addition agency reports included some recommendations which this review endorses.

11.2. The NSCB are currently implementing recommendations following a Serious Case Review into the death of Baby Eve. There are some parallels between the two cases and the learning points from the Baby Eve Overview Report are reproduced in Appendix 5. This is to avoid any potential duplication of activity, and have been considered by the lead reviewer when producing the recommendations for this review.

11.3. The purpose of providing additional recommendations is to ensure that the NSCB and all professionals in the partner agencies of the Board are confident that the areas identified as of concern in this review are addressed. Furthermore, it is recognised that NSCB has recently considered recommendations from a SCR undertaken regarding a case with similar circumstances to this case. It is important for actions taken in respect of these recommenda-

[9] Brandon et al. Lessons from Serious Case Reviews. 2012

tions make recognition of the other report so there is no duplication of effort or dilution of purpose. The lead reviewers have had the opportunity to see the previous serious case review and have taken the recommendations from that review into account.

Recommendation1

The NSCB to ensure that when a Child and Family or Parenting assessment is undertaken following a referral that the agencies that have the best knowledge of the family participate fully in the assessment process. Where the referral is made due to concerns about the mental health of a parent all efforts should be made to ensure the GP contributes to the process and where a mental health assessment has recently taken place, the psychiatrist who has undertaken it should be invited to key meetings and a request made for them to contribute to the assessment.

Recommendation 2

The NSCB to ensure that when a plan is put in place to support children who may be at risk of harm, that all agencies engaging with the family have a clear single record circulated of what the plan is and, if applicable, the role they have to play in delivering it. The plan must have a clear remit (i.e either a CP Plan, a CinN plan or an Early Help Plan).

Recommendation 3

The NSCB should inform all partner agencies of its expectation that all relevant staff who are likely to work with non-mobile babies should refer any bruising they see on the child to Children's Services.

Recommendation 4

The NSCB to ensure that arrangements are in place to develop better communication between mental health professionals and universal services for children where there are concerns around a patient's mental health.

Recommendation 5

The NSCB to ensure that all agencies can evidence that their work with children and families is subject to professional challenge, critical analysis of the information gathered, and that a robust process is in place to audit this. This could be through a multi-agency case file audit or a Section 11 challenge event.

Recommendation 6

That the NSCB asks all partner agencies to ensure that existing auditing activity on cases where parents or significant adults have mental health issues, domestic abuse and / or substance or alcohol misuse, includes the auditing of reflection and challenge.

APPENDIX 1

TERMS OF REFERENCE AND PROJECT PLAN

SCOPE OF THE REVIEW

This serious case review is in respect of **Kirsty**. However information in regards to the sibling Lydia and both parents will also be considered.
Time period: **From May 2009 until 14 August 2014** (Date Kirsty was discharged from hospital) However the review will specifically concentrate on the time around the birth of Lydia and the first months of her life, the safeguarding concerns that emerged in the intervening years and then around the ante-natal period and birth of Kirsty.

FRAMEWORK

Timescale for Serious Case Review completion:
The LSCB should aim for completion of an SCR within six months of initiating it. If this is not possible (for example, because of potential prejudice to related court proceedings), every effort should be made while the SCR is in progress to: (i) capture points from the case about improvements needed; and (ii) take corrective action.

Agreeing improvement action:
The NSCB should oversee the process of agreeing with partners what action they need to take in light of the SILP SCR findings.

Publication of reports:
All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB's website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report will be published should be taken into consideration. SCR overview reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.

This review will adhere to the guidance for SCRs included in Working Together, which states that reports should:

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike.
- be suitable for publication without needing to be amended or redacted.
  (Working Together 2013 p71)

AGENCIES TO BE INVITED TO PARTICIPATE IN THE REVIEW

Children's Services

Northumberland, Tyne and Wear NHS Foundation Trust (NTW)

Northumbria Healthcare NHS Foundation Trust (NHCT)

NHS Northumberland Clinical Commissioning Group (CCG) – GP service

Northumbria Police

TERMS OF REFERENCE

The serious case review should consider the information held by agencies in the time period. Any significant incident/information from outside of the timeframe of the review should also be considered and shared with the Reviewer.

Case Specific Terms of Reference and questions to be answered by agencies involved

Provide an analysis of your agencies involvement, as shown in the chronology you have provided, by answering the following questions in detail. Give examples where possible to evidence your analysis and provide contextual information.

1. What assessment was undertaken in regards to Mother and Father and their parental capacity? What assessment was undertaken of the wider families support? What consideration was given to thresholds for intervention and referral to other services? How timely was the work undertaken with the family?

2. When referrals to other services or internally were made, how robust was the information sharing and what was the quality of the information shared?

3. What was known in your agency regarding the following issues in the family:
    - Domestic abuse
    - Alcohol use
    - Mental health issues
    - The impact of bereavement
    - Family background of the parents
4. What awareness was there in your agency of the plan for work with the family/children? How effective was the planning? Were roles clearly defined, and were the family engaged/involved?

5. What supervision was accessed and what support did staff have in regards to reflecting on their work with this family?

6. What challenge was there in regards to the professional's view of the family?

7. What was the understanding of professionals about the research and best practice regarding bruising in non-mobile infants?

8. Were the children central to the work undertaken with the family?

9. What consideration was given to the provision of early help services?

10. At any point in the work undertaken with the family was consideration given or should have been given to escalating professional concerns?

11. Had the professionals involved in this case received the required level of safeguarding children training?

TIMETABLE

Scoping / terms of reference	19.3.15
Commissioning letters	19.3.15
Authors Briefing	19.3.15
Agency Reports returned to NSCB	5.5.15
Distribution of chronology and agency reports to all attendees	8.5.15
Learning Event	14.5.15
Drafting 1st report and distribution	19.6.15
Recall Event	3.7.15
V2 report circulated for final comment	10.7.15
Final comments on overview report	24.7.15
V3 report submitted to NSCB	31.7.15
Sign off by NSCB	to be confirmed asap

Meetings with Family/Significant Others
Pending agreement from Police and family

APPENDIX 2

AGENCY REPORT PRO-FORMA

AGENCY REPORT

(name of agency)

Serious Case Review

SUBJECT : Kirsty

BORN : 25.6.2014

SERIOUS INCIDENT : 13.8.2014

Name of author:
Job title:
Date:
Agreed by senior manager:

SCOPE
This serious case review is in respect of **Kirsty**. However information in regards to the sibling Lydia and both parents will also be considered.
Time period: **From May 2009 until 14 August 2014** (Date Kirsty was discharged from hospital) However the review will specifically concentrate on the time around the birth of Lydia and the first months of her life, the safeguarding concerns that emerged in the intervening years and then around the ante-natal period and birth of Kirsty.

Section 1 – Summary of involvement
Summarise in brief narrative form the role your agency had in this case. The chronology provided will provide the detailed contacts, services provided and decisions reached.

Section 2 – Other Relevant Information
Report any significant information prior to the timeframe of the review which you consider to be relevant to the learning.

Section 3 – Terms of Reference

Provide an analysis of your agencies involvement, as shown in the chronology you have provided, by answering the following questions in detail. Give examples where possible to evidence your analysis and provide any contextual information.

1. What assessment was undertaken in regards to Mother and Father and their parental capacity? What assessment was undertaken of the wider families support? What consideration was given to thresholds for intervention and referral to other services? How timely was the work undertaken with the family?

2. When referrals to other services or internally were made, how robust was the information sharing and what was the quality of the information shared?

3. What was known in your agency regarding the following issues in the family:
    - Domestic abuse
    - Alcohol use
    - Mental health issues
    - The impact of bereavement
    - Family background of the parents
4. What awareness was there in your agency of the plan for work with the family/children? How effective was the planning? Were roles clearly defined, and were the family engaged/involved?

5. What supervision was accessed and what support did staff have in reflecting on their work with this family?

6. What challenge was there in regards to the professional's views of the family?

7. What was the understanding of professionals about the research and best practice regarding bruising in non-mobile infants?

8. Were the children central to the work undertaken with the family?

9. What consideration was given to the provision of early help services?

10. At any point in the work undertaken with the family what consideration was or should have been given to escalating professional concerns?

11. Had the professionals involved in this case received the required level of safeguarding children training?

Section 4 – Conclusions and Recommendations

In your conclusion please consider learning for your agency and multi agency learning as separate issues. Highlight strengths and good practice as well as weaknesses.

You are required to consider how you will recommend relevant improvements that may be made to services. Please arrange them as follows:

Recommendation	Detailed actions	Person responsible	Timescales	Desired Outcome

APPENDIX 3

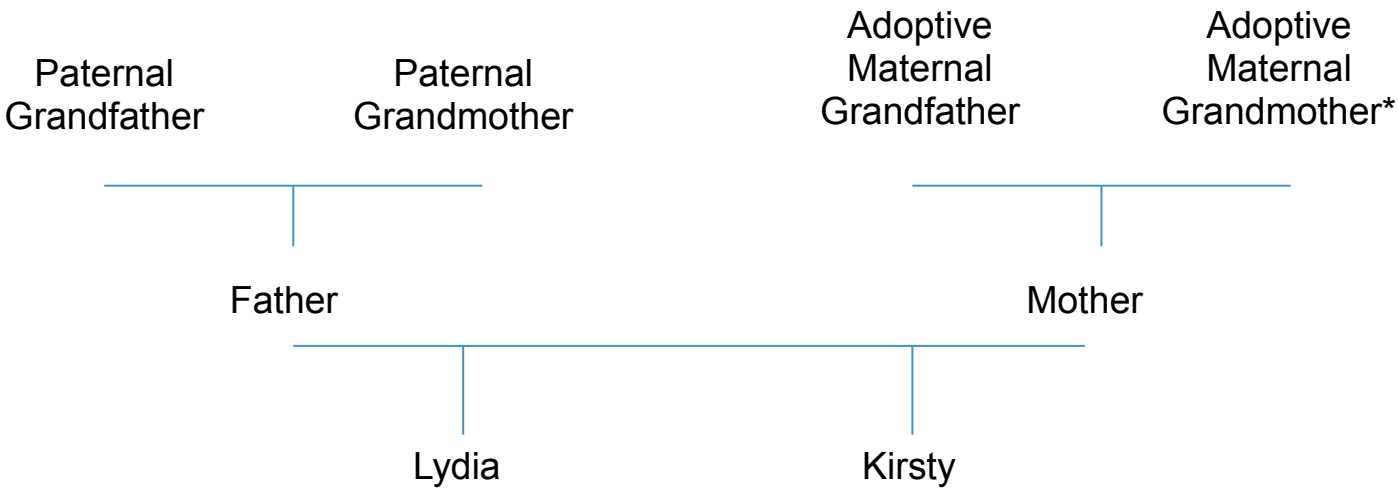
ACTION PLAN

Recommendation	Detailed Actions	Person Responsible	Timescales	Desired Outcome
Recommendation 1 The NSCB to ensure that when a Child and Family or Parenting assessment is undertaken following a referral that the agencies that have the best knowledge of the family participate fully in the assessment process. Where the referral is made due to concerns about the mental health of a parent all efforts should be made to ensure the GP contributes to the process and where a mental health assessment has recently taken place, the psychiatrist who has undertaken it should be invited to key meetings and a request made for them to contribute to the assessment.				
Recommendation 2 The NSCB to ensure that when a plan is put in place to support children who may be at risk of harm that all agencies engaging with the family have a clear single record circulated of what the plan is and, if applicable, the role they have to play in delivering it. The plan must have a clear remit (i.e either a CP Plan, a CinN plan or an Early Help Plan).				
Recommendation 3 The NSCB should inform all partner agencies of its expectation that all relevant staff who are likely to work with non-mobile babies should refer any bruising				

they see on the child to Children's Services.				
Recommendation 4 The NSCB to ensure that arrangements are in place to develop better communication between mental health professionals and universal services for children where there are concerns around a patient's mental health.				
Recommendation 5 The NSCB to ensure that all agencies can evidence that their work with children and families is subject to professional challenge, critical analysis of the information gathered, and that a robust process is in place to audit this. This could be through a multi-agency case file audit or a Section 11 challenge event.				
Recommendation 6 That the NSCB asks all partner agencies to ensure that existing auditing activity on cases where parents or significant adults have mental health issues, domestic abuse and / or substance or alcohol misuse, includes the auditing of reflection and challenge.				

APPENDIX 4

GENOGRAM


Paternal Grandfather
Paternal Grandmother
Adoptive Maternal Grandfather
Adoptive Maternal Grandmother*
Father
Mother
Lydia
Kirsty

* Deceased

APPENDIX 5

KEY LEARNING POINTS FROM BABY EVE SCR OVERVIEW REPORT

The key learning themes from the Baby Eve SCR are reproduced below. Where these are also themes that were also present with Baby Kirsty, this will be indicated:

Views of Eve's Parents

The parents outlined that they considered communication from professionals to be poor and they didn't feel supported to get involved. They felt they didn't get good information in relation to co-sleeping and that the assessment or written agreement was of little value.

This was also a theme in the Baby Kirsty case.

Understanding and working with children's experiences

The review stated that it was difficult to see the children's experiences being considered as central to professional practice.

This was also a theme in the Baby Kirsty case.

Assessment, thresholds for action and decision-making

The review highlighted major flaws in assessment and found examples of flawed application of thresholds and decision-making apparent in the case. It cited evidence of over optimism from professionals. The GP assessments of Mother's wellbeing and capacity almost never led to any further action in relation to the welfare of the children and this was compounded by the lack of contribution to the child protection conferences. Critical information was as a result not available to inform any assessments being made and subsequent decision making.

This was also a theme in the Baby Kirsty case.

Commitment and contribution to multi-agency safeguarding and information sharing practice

Information sharing in the case often failed to ensure accurate assessments and plans were in place for the children. Where there were clear gaps in communication more assertive engagement should have been sought and management escalation used to assist improvements in practice.

This was also a theme in the Baby Kirsty case.

Reflecting on practice: supervision, professional challenge and leadership

The supervision of practitioners working with Eve's family does not appear to have allowed for challenge and any error correction in thinking, analysis or planning. There was no evidence found that the GP Practice contacted the safeguarding team, designated nurse/ doctor or named GP for advice or support. Much more challenge should have been pro-

vided by the child protection conferences and in particular by the conference Chairperson.

This was also a theme in the Baby Kirsty case.

Procedural guidance and recording

There was procedural confusion with a number of documents apparently guiding action regarding substance misusing pregnant women and with no consistent cross referencing between them. Record-keeping policy was not always followed and very often telephone calls and emails were not recorded or uploaded onto the health records electronic system.

This was also a theme in the Baby Kirsty case.

Organisational factors

A number of organisational changes in management and personnel structures were commented upon as negatively impacting on practice.

For more detail, the full summary of the key learning can be found in Chapter 3 of the Baby Eve SCR Overview Report can be found using the following link:

http://www.northumberland.gov.uk/WAMDocuments/9154C041-40AC-410B-BC8A-09C561D40503_1_0.pdf?nccredirect=1