Executive summary of the
Serious Case Review using the
Significant Incident Learning Process
of the circumstances concerning

# Natalie

Independent reviewer:
Karen Rees

Proportionate Serious Case Review Summary: Developed by Margaret Tench Designated Nurse, Northumberland Clinical Commissioning Group and Robin Harper-Coulson Northumberland Safeguarding Children Board Businesss Manager, October 2018

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## 1. Introduction

1.1. This Proportionate Serious Case Review Summary was developed from the full serious case review by the Designated Nurse for Safeguarding Children Margaret Tench and the NSCB Business Manager Robin Harper-Coulson following guidance from the National Panel.

1.2. Natalie was a six-week-old baby who lived with her Mother and 28-month-old sibling. In 2016 Mother contacted the 111 service reporting that Natalie was unresponsive. Natalie was transported to the Acute Hospital by paramedic ambulance with Mother. Assessment at the hospital indicated serious concerns. Investigations revealed injuries belied to be caused by shaking. The situation moved from concerns about an ill baby to concern about non-accidental injuries. Natalie now has significant special needs as a result of her injuries. Neither parent could provide an explanation for the injuries.

1.3. The Serious Case Review was undertaken following a notification of the childcare incident to Ofsted on 04.05.2016 and subsequent discussions with the National Panel which concluded that the criteria for a Serious Case Review was met.

1.4. The request for a Serious Case Review was agreed by the Independent Chair of the NSCB on the 15.08.2016 following discussions with the National Panel.

1.5. The NSCB agreed to undertake this review using the Significant Incident Learning Process (SILP), a learning model which engages frontline staff and their managers in reviewing cases, focussing on why those involved acted in a certain way at the time.

### Process

1.6. Following the decision by NSCB to commission a SCR, a scoping meeting and authors' briefing took place on the 8th November 2016 to agree the Terms of Reference with representatives for NSCB and to introduce the SILP model process and expectations to authors of agency reports.

## 2. Parallel Proceedings And Family Involvement

2.1. During the review there were ongoing criminal investigations and care proceedings.

2.2. Northumbria Police did not give consent for the family to be approached by the author prior to the conclusion of the criminal investigation. This decision was respected and therefore arrangements to meet with the family were not possible. This led to gaps in the in the interim report concerning the views and perspectives of the family on information provided by professionals and the services they received.

2.3. The status of the criminal process at the time of writing the initial overview report and from knowledge and information gathered in undertaking this review, provided no

indicator as to what happened either at the time of or leading to the injuries to Natalie. This review is therefore written without that knowledge initially and will have been updated as information became available and the family could be involved. This did not, however, prevent lessons being learned on how agencies worked together, nor has it prevented recommendations and learning being applied across agencies. At the time of the updated report, recommendations and actions are largely completed or nearing completion.

2.4. The criminal proceedings were concluded in the early part of 2018. Neither parent was found culpable of causing the injuries to Natalie. There were ongoing care proceedings. In order to allow full involvement of parents. Following the conclusion of criminal and care proceedings, the parents were offered the opportunity to share their experiences of agency involvement during the scope of the review.

2.5. For the purposes of this executive summary, the family will be known in the following way:

| Family member: | To be called: |
|---|---|
| Mother of Natalie | Mother |
| Father of Natalie | Father |
| Natalie's sibling | Natalie's sibling or sibling |
| Half siblings of Natalie | Father's older children |
| Father's previous partner | Father's previous partner |

## 3. BACKGROUND PRIOR TO THE SCOPED PERIOD

3.1. Very little is known about Mother prior to the scoping period and no agency had knowledge of any significant involvement. The GP report from Area A indicated that Mother had been known to the practice since her early teens. The GP described her as not unlike many other young women registered with the practice; she did not stand out in any way.

3.2. Information held within Police and GP records indicate that Father had been known to be involved with violent assaults, experimentation with class A & B drugs[1], prescription medication and alcohol prior to the scoping period and that he had

[1]Under the Misuse of Drugs Act 1971, illegal drugs are placed into one of 3 classes - A, B or C. This is broadly based on the harms they cause either to the user or to society when they are misused.

- Class A drugs include: heroin (diamorphine), cocaine (including crack), methadone, ecstasy (MDMA), LSD, and magic mushrooms
- Class B includes: amphetamines, barbiturates, codeine, cannabis, cathinones (including mephedrone) and synthetic cannabinoids. • …. cont.
- ….cont. Class C includes: benzodiazepines (tranquilisers), GHB/GBL, ketamine, anabolic steroids and benzylpiperazines (BZP).http://www.talktofrank.com/faq/what-drug-classification-system

been registered with the same GP practice since birth.

3.3. Father's contact with agencies does provide some useful and important background and, although originally not set as part of the scope of the review, it was felt to be important enough to be brought into scope and therefore forms Key Episode One.

## 4. KEY EPISODES

### Key Episode One: History of Father and knowledge by agencies

4.1. This episode focuses on what agencies knew of Father's history in Area B, There was a history of interventions related to violence and domestic abuse with a previous partner.

4.2. There was a clear pattern of escalating reports of domestic abuse in Father's previous relationship known to the Police across Area A and B (same force area) and to CSC in Area B. However the history from Area B was unknown until this review.

4.3. Information was held by fathers GP in Area A.

### Key Episode Two: Parental Relationship and Family Life

4.4. Information recorded on a health assessment by the health visitor after the birth of Natalie and contained within the GP record for Mother, indicates that the couple had been in an 'on/ off' relationship for three to four years.

4.5. Mother came into contact for health reasons with her GP, Walk in Centre, Accident & Emergency and Maternity Unit.

4.6. These attendances at various health settings provided an insight that Mum's GP and other health services did not have a full understanding of the relationship.

4.7. Documentation by both the midwife and health visitor during the ante natal period for Natalie's sibling then indicated that Mother informed practitioners that she was not in a relationship with the Father but that he would be supporting her.

4.8. Father was not registered at the same GP practice and therefore the midwife did not have direct access to information regarding Father's older children. Routine domestic abuse screening was undertaken, and no disclosures were made.

4.9. The health visitor carried out the Tynedale Health Needs Assessment (THNAT) at the ante natal contact as per the Healthy Child Programme (HCP)[2], again history was detailed as above, and no disclosures of domestic abuse were made. Mother was nineteen years old at the time and consented to a referral to the teenage pregnancy team. At that time all pregnant mothers under 20 years old were referred to the Teenage Pregnancy Team[3]. Mother indicated that she had good family support and would not require the additional support offered.

4.10. As was usual practice, the midwife visited three times postnatally and no concerns were highlighted. It is not documented who was present at any of these visits.

4.11. At the new birth visit to Natalie's sibling by the health visitor, as per HCP, baby was observed to be well, gaining weight and positive interaction was noted between mother and baby. Maternal Grandmother was present and was noted to be caring towards her daughter and baby. Father was not present at any contacts at this time.

4.12. During this time, there is little mention of the Father or the parental relationship.

4.13. In August 2014, when sibling was seven months old, there was a verbal altercation that resulted in a CCN to Area A CSC. As this was a significant incident in understanding the lives of the family, it has been identified as a Key Episode and is explored further below (4.18).

4.14. At the booking appointment with the second pregnancy, with the midwife, routine screening for domestic abuse was carried out and there was no disclosure. The midwife was not aware of the domestic incident the previous August. This is discussed further in the next Key Episode and analysis.

4.15. At 28 weeks' gestation, Mother attended the Maternity Assessment Unit at Area C hospital with trauma to the abdomen and cramping. Mother reported that she had an accident at work and hit her 'bump'. This explanation was accepted, and examination identified no concerns for the baby. This incident was documented in the GP records by the community midwife in Area A when she had been notified by Mother about her attendance. The recording by the midwife related to the fact that Anti D[4] had been given due to this incident as opposed to the mode of the incident in itself.

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[2] The HCP offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing.27 Oct 2009 Healthy Child Programme - Gov.uk

[3] Teenage Pregnancy Team: With consent, referrals were made for all under 20's. Contact would be made to identify any support that may be required.

[4] Giving Ant D can help to avoid a process known as sensitisation, which is when a woman with RhD negative blood is exposed to RhD positive blood and develops an immune response to it.
Pregnant women are offered anti-D immunoglobulin if it's thought there's a risk that RhD antigens from the baby have entered the mother's blood – for example, in the event of any abdominal injury.
http://www.nhs.uk/Conditions/Rhesus-disease/Pages/Prevention.aspx

4.16. Postnatally, assessments by midwife and health visitor did not raise any concerns. The health visitor met the Father for the first time as it was noted that, although the couple did not live together, he was there to offer support due to the traumatic delivery and immediate post-natal complications.

4.17. During this period Father was attending his own GP with issues that none of the agencies working with Mother and children were aware of. Father's GP was not aware that he was a Father or that he had been an alleged perpetrator of domestic abuse in his previous or current relationship. Father continued to be reported to reside with his parents in Area B and accessed his GP in Area B.

4.18. In September 2013 Father attended his GP on two occasions. The first time he saw a locum GP as he had been advised by his 'bosses' to seek help as he had slept in, was not dressing well and was not himself. It was also recorded that he had money issues and a third child on the way, which the locum recorded that Father had felt that he had reluctantly accepted. This is the first time that Father was identified as a parent. Counselling was offered but not readily accepted and a suggestion by the GP of time away from work was not accepted due to money issues.

4.19. During the timescale of the review, Father's GP recorded several attendances and contacts related to musculoskeletal pains in the back, for which Father was seeking codeine[5]. This was not always prescribed and on 2 occasions, Father re-contacted the surgery stating that the prescribed medication did not work and then codeine was prescribed. On the final occasion a stronger codeine dose was requested, and this was agreed.

4.20. Father also sought help for smoking cessation and records indicated that this was successful as the recorded levels of Carbon Monoxide had reduced. In March 2016, Father had reported to the practice nurse that he had no problems with the smoking cessation programme stating he was 'a little grumpy but manageable'.

4.21. One of the significant issues discussed at the Learning Event relates to the NSPCC programme called 'Coping with Crying' that has been adopted in Area A. This programme includes a requirement from the NSPCC during its research, that it is best practice for all parents to be shown the DVD and given a leaflet about how to soothe crying babies and points out the dangers of shaking a baby. In this case, the programme was not in place at the time of Natalie's sibling's antenatal and post-natal period. Both parents were present, however, when the leaflet was shared after Natalie's birth, but the health visitor did not have access to a DVD player or any

[5] Codeine is a moderately strong opiate drug that is used in pain relief and for the suppression of coughs. But strong or weak, it is still an addictive drug with many symptoms of use in common with other opiates.
http://www.narcononuk.org.uk/drug-abuse/codeine-signs-symptoms.html

alternative method of the parents viewing the film. This issue and the difficulties with practical application of this programme are discussed further in the analysis.

### Key Episode Three: Domestic incident August 2014

4.22. There was only one occasion where any domestic abuse in the parental relationship came to the attention of agencies and therefore to ensure that any learning from this incident is recognised it forms a separate Key Episode.

4.23. In August 2014, police were called to an incident involving a verbal altercation between the couple at Mother's address. There were several people socialising at the address when the police arrived. Officers attending assessed the incident using the DASH[6] risk assessment as standard risk. Police officers asked Father to leave the premises, which he did, and no further action was taken as no offences were disclosed. Mother was offered services of Independent Domestic Violence Advisor (IDVA)[7] support if required but this was declined. Information also indicated that the couple were no longer in a relationship.

4.24. A CCN was sent to CSC in Area A. There was a discrepancy in the understanding of the presence of a child at this incident. At the Learning Events the police confirmed that the generation of the CCN would infer that a child was present but that the conversation between the social worker and the health visitor (see below 4.21) was that there was no indication detailed in the CCN of where the child was at the time. This notification detailed the previous history of Father and domestic incidents that had taken place with the former partner but that this incident was the only one in the last 12 months. No contact was made with the police by the duty social worker considering the incident to explore more about the previous domestic incidents or clarification as to the whereabouts of the sibling at the time.

4.25. Because of the notification, the social work team manager instructed the duty social worker to make a visit. There were two failed attempts to see the family. On the day of the second failed visit, the social worker contacted the health visitor. The health visitor informed the social worker that there were no concerns about the family and

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[6] DASH stands for domestic abuse, stalking and 'honour'-based violence. It is based on research about the indicators of high-risk domestic abuse. The simple series of questions makes it easy to work out the risk a victim is facing. A high score means the victim is at high risk of murder and/or serious injury and needs urgent help. http://www.safelives.org.uk

[7] The main purpose of independent domestic violence advisors (IDVA) is to address the safety of victims at high risk of harm from intimate partners, ex-partners or family members to secure their safety and the safety of their children. Serving as a victim's primary point of contact, IDVAs normally work with their clients from the point of crisis to assess the level of risk, discuss the range of suitable options and develop safety plans. http://www.safelives.org.uk/

that Mother engaged well with clinics and groups. The health visitor and the social worker did not discuss if the health visitor had met Father.

4.26. At this point Area A CSC were not aware of the previous involvement of CSC in Area B related to Father's older children who resided there. No further action was taken by Area A CSC.

4.27. In line with the process at the time, the CCN was shared verbally with the health visitor for information but without the information related to the previous incidents. The health visitor did not know of the previous incidents in Area B. As a result of her own knowledge of the family, the fact that the current incident was risk assessed as standard, that CSC were taking no further action and that this was a verbal altercation at a 'party', the health visitor did not follow this incident up with the parents.

4.28. When Mother became pregnant again, the THNAT was not completed by the health visitor antenatally due to Mother's work commitments and scheduling issues for the health visitor and was commenced at the first visit to Natalie. Although all newly pregnant women are discussed between the midwife and health visitor, the domestic incident of August 2014 was not raised at this time, the midwife was not aware of the incident, but it was recorded on the GP record by the heath visitor. It is not clear if the midwife was aware of the information on the record at the booking visit as this was a relief midwife who did not have access to the GP record system in the same way that the regular midwife does.

4.29. At the new birth and follow up visits to Natalie, when the THNAT was undertaken, the issue of the domestic incident could not be raised as Father was present, nor was the usual domestic abuse enquiry question asked for the same reason. The health visitor did intend to address this as soon as she had the opportunity but the injuries to Natalie occurred before further contact could be arranged.

4.30. Following the domestic abuse incident, no checks were made by any agency with the GP for Father, therefore the fact that he had disclosed about his anxiety about becoming a Father for the third time and his potential depression remained unknown.

## 5. ANALYSIS BY THEME

### History informing assessment

5.1. From the information gathered during the process of this review it is clear that very little was known about Natalie and her family. They only became known to services in Area A when Mother presented in her first pregnancy. All assessments at that time were indicative of a family who would not have any additional needs and therefore remained in universal services initially in health and more latterly in the Early Years

setting. These assessments were based solely on what was known about Mother and the observations of the family as a unit which mostly excluded Father.

5.2. In Area A, health visitors use the THNAT which is a robust assessment tool used to discern the level of need. HCP Guidance indicates that, especially in first pregnancy where parents are not known, there are indicators that can be useful in identifying early identification of risk and need.

5.3. It is apparent in hindsight that although information was available it remained largely unknown and unassessed by the practitioners offering universal services in Area A.

5.4. The importance of Father and his history being included in assessment becomes very clear. Without this it is easy to see why risk indicators or protective factors were not recognised.

5.5. The observations that the practitioners made were of a young mother who had good family support. Mother was also observed, once children were born, to be an engaged and caring mother. The impact of the reported on/off relationship was not explored nor were the reasons considered for any difficulties that this may indicate in the relationship.

5.6. The importance of being cognisant and curious of history when undertaking assessments has been a feature of previous serious case reviews nationally.[8] [9] [10].

> **Learning Point 1:**
> Assessment guidelines provide clarity about breadth and purpose. Gathering historical information to inform that assessment provides rigour to the outcome and informs the level of need as well as understanding, risk and vulnerability.
> **Recommendation 1**

### Understanding Domestic Abuse

5.7. Whilst it is not clear how Natalie's injuries were sustained, research into significant harm and severe maltreatment suffered by children shows clear links with domestic abuse.[9] [10] [11] It is therefore important to consider this in agencies' assessment and responses to understand any possible impact on the lived experiences of Natalie and her sibling.

5.8. It is important to note that Mother has made no disclosures of domestic abuse to date. Apart from the verbal altercation that took place in August 2014 there were

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[8] Child N Northamptonshire Safeguarding Children Board 2016
[9] Radford, L. et al. (2011) Child abuse and neglect in the UK today. London: NSPCC
[10] Brandon, M., Belderson, P., et al (2008) Analysing child deaths and serious injury through abuse and neglect: What can we learn? A biennial analysis of serious case reviews 2003–5. London: Department for Children, Schools and Families.
[11] Peter Sidebotham et al. (2016) Pathways to harm, pathways to protection: a triennial analysis of serious case reviews 2011 to 2014 London, Department for Education

no other obvious indicators. The midwife and health visitor asked about domestic abuse as part of routine enquiry in both pregnancies and at the new birth visit to the sibling and there were no disclosures.

5.9. There was a clear pattern of escalating reports of domestic abuse in Father's previous relationship known to the Police across Area A and B (same force area) and to CSC in Area B. Father accepted that this was a volatile relationship and not a positive one.

The incident in January 2011 was recorded and processed as a verbal incident in CSC records. In fact, the Police information stated that this was a physical assault that resulted in a caution. This incident was therefore a physical assault witnessed by a child of the relationship and took place at a time that may have been reasonably close to the start of the new relationship.

5.10. It is of note that in both Father's known relationships there was a feature of the 'on/off' nature of the relationships being reported to Police and CSC. This appeared to lead to an over optimistic view of the reduced risk to the children. Decisions were based on the fact that the volatile nature of the relationship would not be impacting on the children because the relationship was over. There was indeed evidence to the contrary as in both relationships there were further incidents where Father and the previous partner, or Father and Mother were together at the time that the incidents occurred. Had professional curiosity been applied regarding the on/off relationships they would have ascertained that in the first relationship this was volatile and on and off but that in the relationship with Father and Mother, this was due to concerns about benefits.

5.11. There was no understanding as to whether Father would pose a risk in any future relationships. Assessments did not include Father, no one spoke to Father after these incidents and assumptions may have been made. To ensure accurate risk assessment of domestic abuse impact on children, information needs to be fully explored and shared in order to discern if alleged perpetrators are a risk. Appropriate interventions and further assessments can then be based on all knowable information.

5.12. There were several ways that the history of domestic abuse could have been identified, understood and used for assessment of risk within the new family.

5.13. At no time during the interventions for domestic abuse in Area B, was the GP of Father contacted. The GP held relevant information related to Father's history of substance misuse and alcohol use but did not have information that he was an alleged perpetrator of domestic abuse. At a discussion at the Learning Event, it was argued that GPs will not give information to other agencies unless it is for Section 47[12]

[12] Section 47 Children Act (1989): Local Authority duty to investigate where it is made aware that a child might be suffering or likely to suffer significant harm.

enquiry. This is not always the case and usually when there are other clear reasons to share information, in the interests of safeguarding.

5.14. When Area A CSC received notification of the incident in August 2014, as part of the information gathering and risk assessment, contact could have again been made with Father's GP. Whilst the GP would not have known about previous domestic abuse, as he had not been notified, he would have had significant recent history about possible depression and money concerns as well as more historic information that may have been relevant. He would also then have known that he was a Father and an alleged perpetrator of domestic abuse and this may well have been considered for any further presenting issues.

5.15. A full check back with Area B CSC by Area A CSC about the previous incidents would also have provided more details about any possible abuse in the past relationship and therefore any current risk thus encouraging more pursuit of contact with Mother and deciding as to whether it was appropriate to commence a child and family assessment.

5.16. Use of The Domestic Violence Disclosure Scheme (Clare's Law)[13] may also have been a further opportunity to identify if there was a risk. Clare's Law was launched nationwide in March 2014. Mother was given information about the IDVA service. There was also the possibility for Mother and for the others at the house to be made aware of Clare's Law. A leaflet to Mother or others at that point may have encouraged further information being sought that may have led Mother to find out about Father's history.

5.17. When it was known that Mother was again pregnant, the information pertaining to the first domestic incident was not shared with the midwife by the health visitor, nor did the midwife identify the incident from the GP records. This resulted in both the health visitor and the midwife continuing to offer service at a universal level as history of previous domestic abuse was not considered in the assessments they carried out.

5.18. More recently, processes regarding domestic incidents have been amended and police now share CCNs with the health visitors directly. A pathway has been developed to offer guidance to health visitors regarding responses to those notifications. It is of note, however, that the CCN does not provide any history of previous domestic incidents, therefore there is a reliance on the professional in receipt of information to check back for other notifications received.

5.19. The police have since clarified that the history is not included in information sent to other professionals due to the nature and relationships that the notification may

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[13] The Domestic Violence Disclosure Scheme is a national scheme that has been set up to give members of the public a formal mechanism to make enquiries to Police about an individual who they are in a relationship with, or who is in a relationship with someone they know, and there is a concern that the individual may be abusive towards their partner.

relate to e.g. the alleged perpetrator may not be associated with the children involved in the incident on an ongoing basis and this information may be recorded in children's records. This is an important issue that adds weight to learning highlighted above (Learning Pont 2).

5.20. Notwithstanding hindsight bias[14] discussions at the Learning Event also focussed on how more professional curiosity may have provided cues as to what may have been happening within the relationship. The Agency Report Author for the GP practice in Area A was concerned at the number of attendances related to personal health issues and considered that this was over and above the norm. This was alongside a consultation regarding uncertainty about continuing with a pregnancy and attendances at various health services (e.g. Walk in Centres, GP practice and maternity unit).

5.21. A further opportunity for professional curiosity was related to the attendance at the Maternity Assessment Unit with abdominal trauma in the second pregnancy. This was after the first incident of domestic abuse had been identified. The information and detail of the incident on its own may well have been feasible.

5.22. Research regarding intimate partner violence[15] [16] has identified that women experiencing abuse are three times more likely to access emergency departments than non-abused women and seek health services from primary care and women's services more often. It is therefore important to offer opportunities for safe disclosure and make use of selective enquiry where there are cues or indicators such as those presented in this review.

### Role of Father and Think Family

5.23. The work by the author of the CCG Agency Report in relation to the issues of the presentation by Mother for various health issues and at various places, has resulted in learning for GP practices. This will be taken forward into training with GPs and an anonymised version of the facts in this case will be used for scenario-based training.

5.24. One of the key themes throughout all the Agency Reports and noted at the Learning Event, was the lack of information, assessment and understanding by those working with Mother, Natalie and her sibling of the role that Father of took within the

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[14] Roese, N. J., & Vohs, K. D. (2012). "Hindsight bias". *Perspectives on Psychological Science*, 7, 411–426. Hindsight bias occurs when people feel that they "knew it all along," that is, when they believe that an event is more predictable after it becomes known than it was before it became known. Hindsight bias embodies any combination of three aspects: memory distortion, beliefs about events' objective likelihoods, or subjective beliefs about one's own prediction abilities.

[15] Campbell, J. C .(2002) Health consequences of intimate partner violence. The Lancet; Vol 359 • April 13, 1331-1336

[16] Plichta, S. (1992) The effects of woman abuse on health care utilization and health status: A literature review. Women's Health Issues, Volume 2, Issue 3, 154 - 163

family.

5.25. Universal health services in Area A focussed on the needs of Mother and her

**Learning Point 2:**
Risk assessment following domestic abuse incidents must be based on accurate and full relevant information being shared and robust assessment of all information and history in order to achieve best outcomes for children and adult victims. Alleged perpetrators should also be considered and spoken to in follow up and assessment.
**Recommendation 1 & 2a**

**Learning Point 3:**
Where CCNs are shared it is important that practitioners understand what response is required of them. **Recommendation 1& 2b**

**Learning Point 4:**
Professional curiosity and further assessment of the nature of reported on/off relationships, particularly where evidence would suggest otherwise, may afford greater understanding of any risk to children (or not) exposed to domestic abuse.
**Recommendation 1 & 5b**

**Learning Point 5:**
GPs of perpetrators of domestic abuse may hold valuable information to inform risk assessment and protect children.
GPs may be the constant service offered to domestic abuse perpetrators and require robust information to inform their assessment and information sharing.
It is important for GPs to know and record males who are fathers in order that the significance of that information can be weighed up against the reasons for consultation.
**Recommendation 1 & 3a-c**

**Learning Point 6:**
Where national initiatives such as Claire's Law may not be widely understood by members of the public it is important for professionals to be knowledgeable about these e.g. including information in briefings and training so that professionals can promote these in order that they can be effective.
**Recommendation 4**

children. They did not have very much contact with Father, so he did not feature in assessments that were carried out.

5.26. Engaging fathers has been the subject of focus in previous serious case reviews[17]. When fathers are either not engaged or where their role in the family is not understood, professionals are left not knowing to what extent a father may be a risk or protective factor within a family. In this case, nothing of concern was noted and no concerning behaviours were observed.

5.27. Where parents have a mental health issue and are accessing support for that, it is important that professionals identify the adult that they are seeing as a parent and

[17] https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/hidden-men/

adopt a 'Think Family' approach to understand the possible impact of parental mental health on any children in the family. This helps practitioners to identify protective factors and support networks against risk and vulnerability in the context of the parental mental health and children's needs. It would have provided evidence of thorough assessment of these issues and any impact on the children. Further probing by the Father's GP may have identified his partner and children and enabled information sharing between health services in Area A and Area B.

5.28. Results from the NSPCC research[18] into the Coping with Crying programme have shown positive results. When parents have seen the film, they have an increased understanding about infant crying, are more likely to respond positively to their baby's crying and are more confident in seeking support and help.

**Learning Point 7:**
There are associated risks by not engaging with and assessing potential threats that fathers may pose to children and/or their partner as well as understanding any protection and support they may offer. Fathers' needs are as important as mothers. Where fathers are absent, actively engaging them and exploring with the mother the role that fathers play in the lives of children is important. Understanding both parental roles and needs can improve outcomes for children. **Recommendation 1, 5a &c**

**Learning Point 8:**
Application of theoretical frameworks can help to refocus assessments and provide an evidence base for concern, as well as providing good quality information for onward referrals related to specific issues of risk and vulnerability. **Recommendation 1**

**Learning Point 9:**
Where practitioners are required to undertake an intervention, it is important that barriers to compliance are addressed in order that families receive the information that has been established as a benefit in the protection of children. In the case of the Coping with Crying programme, a fresh approach to implementation may increase the numbers of parents that view the DVD. **Recommendation 6**

## 6. GOOD PRACTICE

It is important to note that most practitioners offer a good level of service to their clients/patients and follow policies and procedures that are provided to guide practice. Whilst recognising gaps in practice, Serious Case Reviews can also provide evidence of this as well as practice that goes over and above what is expected.  Agency Reports and attendees at the Learning Events were asked to identify these from their own and other agencies. It is important to highlight these as areas where learning can occur and to recognise good practice.

- CSC in Area A decided to contact Mother despite there only being one incident of domestic abuse notified
- Police attended the incident in 2014 and recognised it as a domestic incident and risk assessed it appropriately.

[18] https://www.nspcc.org.uk/

- A consistent service was offered by midwifery and health visiting teams with practitioners remaining the same throughout the timescale of this review
- Throughout the review it was noted that domestic abuse routine enquiry was understood and carried out by health services following NICE Guidance.
- The THNAT was used and provided a good basis for understanding the needs of Mother and the children
- Good communication from the health visitor identified an updated address for CSC to contact Mother.
- GP practices in Area A have regular safeguarding meetings with health visitors and midwives with templates for the meetings and a robust referral system for cases that require information sharing. An administrator attends these meetings and adds appropriate 'read codes' to GP records following the meetings.
- The Safeguarding Lead GP at Mother's GP practice has developed an automatic trigger system for cases that need discussion via a 'hit the red button' system.

## 7. CONCLUSIONS AND LESSONS LEARNED

7.1. The events leading up to the injuries to Natalie are unknown by professionals and therefore it is difficult to identify exactly which focus might have provided more insight into pathways to harm.

7.2. Previous studies into serious case reviews nationally, have highlighted that professionals must maintain a healthy scepticism and respectful uncertainty to see beyond what is often being presented by parents. A process of 'checking back' with professional colleagues may provide opportunities to detect hidden issues and further provide pathways to protection.
Use of the Pathways to Harm model helps to identify where more professional curiosity and application of evidence-based practice may have afforded pathways to protection.

7.3. In this, case various indicators of harm were related to:

- Father's history, his potential significant untreated depression.
- Father being an alleged perpetrator of domestic abuse in his previous relationship.
- Age and therefore vulnerability of the children especially Natalie.
- Young parents.

7.4. Good information sharing and contacting the professionals that may well hold key information about a whole family and use of Think Family approaches may have afforded the right information to inform robust assessments of elements of risk and therefore inform the level of service that would possibly provide prevention from harm.

7.5. If Father's GP had known that he was an alleged perpetrator of domestic abuse and a father of four children, given the diagnosis of significant depression, this may have caused contact at least with the health visitor or GP for the Mother and children and could have led to a reassessment of the current situation and more support for the family.

7.6. Exploration by CSC in Area B about the nature of the last episode of domestic abuse in the first relationship being one of a physical assault in front of a child may have led to more assessment and probing into Father's background and contact with his GP.

7.7. Information being shared with the health visitor about the nature of previous incidents that Father had been involved in may have led to a more robust assessment of Mother and opportunity to for her talk more about any issues in her the relationship.

7.8. If Mother's GP had opportunities to reflect on the number of issues that she was presenting with and the number of places she was accessing for advice and treatment it may have been an alert to probe further about why this was and share information with other health professionals that were seeing her in order to offer any support she needed.

7.9. It is important that as well as individual professionals' curiosity, to consider how systems and policies can support prevention and protection.

7.10. The system of information sharing related to domestic abuse across the locality needs to be reviewed so that the understanding and assessment within families by all professionals is robust and is informed by all the information that is available and therefore leads to recommendations for the LSCB to consider.

7.11. It is the case that in some instances Serious Case Review meetings between family and authors have been successfully undertaken without prejudicing other proceedings. Use and knowledge of disclosure issues are an important factor that need to be understood. Engagement from families much later in the process can limit the effectiveness of the review process and therefore the learning.

> **Learning Point 10:** Delays due to criminal or other proceedings lead to limited engagement with families much later in the process and limit learning and improvement. Understanding and challenging that SCR processes are also mandated under legislation and can sometimes be undertaken simultaneously should encourage challenge and further discussion. Reassurance regarding SCR process and understanding of issues that should lead to disclosure can be helpful.
> **Recommendation 7**

## 8. RECOMMENDATIONS

8.1. The learning in this case provides a window on the system. Information gathered during this review suggests that the issues that it has highlighted may have

implications for the wider system. The following recommendations therefore seek to address this.

8.2. This Serious Case Review covers services offered within 3 LSCB areas; professionals from those areas were fully engaged with the SCR. Arrangements must be made to share relevant learning from this SCR with Area B and C LSCB.

8.3. Where agencies have made their own recommendations in their Agency Reports, the three LSCBs should seek assurance that action plans and are underway and outcomes are impact assessed within those organisations.

8.4. The following recommendations are made as a result of the learning in this case and require that **NSCB seeks assurance from** the appropriate partners that the following are addressed:

1. That partner agencies who carry out assessments of need ensure that processes and practice provide adequate scope to include all relevant history pertaining to family history especially for absent parents and carers as well as drawing on 'Think Family' approaches (Learning Point 1-5, & 7- 8).

2. That partner agencies across the NSCB area:

    a. Evaluate the information that is shared regarding domestic abuse notifications to ensure it provides robust information for on-going assessment (Learning Point 2).

    b. Ensure that there is guidance/policy related to the response to receipt of domestic abuse notifications (Learning Point 3).

3.
    a. That information related to domestic abuse incidents is shared with GPs for the perpetrator as well as for the children and victims (Learning Point 5).

    b. That practitioners who are assessing risk for victims and children ensure that they contact GPs of both victims and perpetrators to include relevant information in order to safeguard children and in the public interest. (Learning Point 5).

    c. That GPs record where male patients in their practice are fathers, especially when their partner and children are registered at a different practice or area. (Learning Point 5).

4. All agencies who encounter domestic abuse victims should promote Claire's Law; consideration should be given to the production of a leaflet

highlighting this where an incident has occurred, and police have been called (in the same way as IDVAs are recommended) (Learning Point 6).

5.
    a. That partner agencies will provide detail of how they will apply the learning in this case regarding assessment and engagement with fathers in their respective organisations and to include how information is shared to GPs when men become fathers and are not registered at the same practice as mothers (in the same/similar way to the notification to mothers' GPs). (Learning Point 7).

    b. NSCB, through its learning and development activity and case auditing, and partner agencies through their supervision, ensure that healthy scepticism and professional curiosity are encouraged and evidenced in practice. (Learning Point 4)

    c. NSCB should formulate guidance on the importance of engaging with fathers. This should include:

        - the importance of gathering background information
        - assessment of needs
        - ensuring unmet needs are supported with appropriate offer of services and/or referrals (Learning Point 7)

6. That NSCB considers interagency support to enhance the roll out of the Coping with Crying programme in light of the learning from this review (Learning Point 9).

7. In recognition that not all cases are the same, NSCB should engage in full discussions and escalate concerns where learning from Serious Case Reviews is affected by ongoing Criminal Processes (In line with CPS Guidance[19][20]).

[19] https://www.cps.gov.uk/sites/default/files/documents/publications/liaison_and_information_exchange.pdf
[20] https://www.cps.gov.uk/legal-guidance/serious-case-review