SERIOUS CASE REVIEW
(Under Chapter 8, Working Together to Safeguard Children 2010)
In respect of the death of a child known as
Child B

OVERVIEW REPORT

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In accordance with statutory guidance this report has been fully anonymised to protect the identity of the family. The deceased child will be referred to as Child B and other family members by their relationship to the child e.g. Mother, Father etc
1 INTRODUCTION

1.1 On an evening in 2012 a 999 telephone call was made requesting an ambulance stating that an 11 month old child was not breathing. The child was found to be unconscious by the paramedics who attended the home address. The parents were both at the home and were unable to provide any explanation regarding what happened. The child was transported to hospital and medical examinations showed that the child had sustained a recent significant head injury, a fractured skull and an intracranial bleed on the brain. A skeletal survey showed further healing injuries; fractures to ribs and clavicle.

1.2 The child died in hospital 4 days later. Father was subsequently convicted of manslaughter in April 2015 and Mother was convicted of allowing the death of a child. Father received a 10 year prison sentence, Mother a 2 year sentence suspended for 2 years.

1.3 In addition to the Police enquiries into this matter, it is a statutory duty of the Safeguarding Children Board to review the circumstances of all child deaths occurring in their area in order to learn lessons and inform strategic planning on how best to safeguard and promote the welfare of children.

1.4 A small number of child deaths are found to have abuse or neglect as an associated factor, and these cases must be brought to the attention of the Chair of the Local Safeguarding Children Board who will consider if a Serious Case Review (SCR) should be undertaken.

1.5 The purpose of a Serious Case Review is outlined in Chapter 8 of Working Together to Safeguard Children, 2010 (WT 2010 – the guidance that was relevant at the time that this SCR commenced) and Statutory Guidance issued by the former Department for Children, Schools and Families. Since this Serious Case Review was commissioned Working Together to Safeguard Children 2010 has been revised, and has been succeeded by Working Together 2013 previous version, as it was started before the new guidance (Working Together 2013) was available. WT 2010 states its purpose as follows:

- to establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- to identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result;
- and, as a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

1.6 The guidance goes on to describe two criteria for undertaking a Serious Case Review:

- ‘when a child dies and abuse or neglect is known or suspected to be a factor in the death, the Local Safeguarding Children Board (LSCB) should always conduct a Serious Case Review
- where a child has been seriously harmed as a result of being subject to sexual abuse, the LSCB should consider whether to conduct a Serious Case Review (paragraph 8.11)’.

1.7 In the light of information made available to him, the then Chair of Telford & Wrekin Safeguarding Children Board (TWSCB) Chris Brannan, decided to conduct a Serious Case Review under the first of these criteria.
1.8 In reaching this decision, the Chair took into account the findings of preliminary inquiries into the lives of the child and family which revealed that:

- The child has not been previously known to Children Social Care or the Police.
- The Mother of the child was 17 years old when Child B was born.
- Child B had been presented to hospital on four occasions in the previous two months with a number of small injuries being recorded.
- The Police were undertaking an investigation into the injuries and subsequent death of Child B, as abuse was suspected.

1.9 This Overview Report brings together and draws overall conclusions from the information and analysis contained in reports from those agencies involved with this child and their family. It highlights what can be learned from this case, and where appropriate it makes recommendations to improve local services for safeguarding children.

1.10 The key learning points in respect of this serious case reviews are as follows:

- All professionals working with children must consistently be aware of the research regarding bruises in infants who are not independently mobile.
- All professionals should consistently consider injuries in children alongside that child's developmental stage.
- All agencies must consistently recognise the importance of assessing fathers and/or partners in their assessments and work with families.
- Recognition of the vulnerability of pregnant teenagers, with all pregnant 16 and 17 year olds being offered a Common Assessment Framework (CAF) assessment of need and an integrated support plan. These assessments should reflect an understanding of how young parents’ experiences of being parented impacts on their capacity to nurture and care for their own children.

2 TERMS OF REFERENCE

2.1 The timeframe for the review and the terms of reference were considered and agreed at a meeting of the SCR panel on 21 September 2012 and are described in the following paragraphs.

2.2 The time period for this Serious Case Review has been set from when Mother became pregnant to 1 month after the death of Child B. This is from 1 January 2011 to 27 August 2012. However information from outside the timeframe will also be considered if it is relevant to the review.

2.3 The decision was made to extend the review beyond the death of the child to see what lessons can be learned with regard to the multi-agency child protection investigation which commenced on 27 July 2012.

2.4 The Terms of Reference are split into two groups.

1) Generic issues, as set out in the Working Together Guidance, which should be addressed in all Serious Case Reviews; and

2) Specific issues that have been identified by the Serious Case Review Group (a sub-group of the TWSCB) as pertinent to this case.

2.5 The generic Terms of Reference are as follows:
were practitioners aware of and sensitive to the needs of children in their work, and knowledgeable both about potential indicators of abuse or neglect and what to do if they had concerns about a child’s welfare?

when, and in what way, were the child’s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?

did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

what were the relevant points/opportunities for assessment and decision-making in this case in relation to the child and family. Do assessments and decisions appear to have been reached in an informed and professional way?

did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made in the light of assessments?

were there any issues in communication, information sharing or service delivery, between those with responsibility for working during normal office hours and others providing out of hours services?

where relevant, were appropriate Child Protection or Care Plans in place, and Child Protection and/or Looked After Reviewing processes complied with?

was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

were Senior Managers, all other organisations and professionals involved at a point in the case where they should have been?

was the work in this case consistent with each organisation's and the LSCB’s policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

Was there sufficient management accountability for decision making?

2.6 As well as the above, all Individual Management Review (IMR) authors were asked to consider the following in their reports:

- Focus on the experience for Child B of living in this family
- Identify lessons to be learnt and translate them into recommendations for action
- Identify areas of good practice
- Consider how and why events occurred, decisions were made and actions taken or not
- Identify whether different decisions or actions might have led to different consequences
- Identify what knowledge agencies had about the relationship between mother and father
- Identify what knowledge agencies had of mother’s teenage pregnancy and how they responded to this, and access and uptake of services
- Identify if there are any cultural issues
- Consider agencies’ knowledge and involvement in key incidents – March, May, June and July
- Consider whether a Common Assessment/Team Around the Child should have been considered at any point during the period covered by these terms of reference
- Consider whether additional referrals to the safeguarding helpdesk have been considered at any point
Consider to what extent was the possibility of abuse considered when Child B presented at the hospital for the first time
Reflect on the effectiveness of communication both within each agency and between agencies
Refer to local policies, procedures and research findings

2.7 Both sets of terms of reference have been used by the IMR authors, the panel and will therefore be referred to in this report as the basis for learning in this case and to influence the recommendations and the action plan.

2.8 On 14 December 2011 John Goldup, the National Director for Development and Strategy at the Office for Standards in Education, Children's Services and Skills (OFSTED), sent a letter to the Directors of Children's Services and Chairs of LSCBs. The letter stated SCRs would be evaluated against 6 learning domains. While SCRs are no longer evaluated by OFSTED, the panel in this case agreed to consider the evidence of learning in this case against the six domains.

3 METHODOLOGY AND THE REVIEW PROCESS

3.1 In completing this Serious Case Review, the Serious Case Review Panel and the Independent Author have followed the guidance laid down in Section 8 of Working Together to Safeguard Children (2010). This review was started before the publication of Working Together 2013 and 2015, therefore it has been completed under the 2010 guidance.

3.2 Initial enquiries instigated by TWSCB following notification of Child B’s death on the date that Child B died indicated that the child and the parents were known to a number of local agencies. In addition to the normal range of ‘universal’ services e.g., midwifery, health visiting, primary care, it became clear that Child B and Mother had also accessed services from a child care provider, hospital services and a supported housing agency.

3.3 All agencies were immediately asked to secure their case records from potential interference pending a decision from the Chair of TWSCB regarding the threshold for a Serious Case Review.

3.4 Within 4 weeks of the child’s death the Chair agreed that the threshold was met and partner agencies of the Board were asked to undertake IMRs addressing the Terms of Reference agreed for the review. (See Section 2).

3.5 To assist the IMR authors in their task, a briefing session was held on 12 November 2012. At the meeting, the independent Chair and author gave advice and guidance on the role of the IMR author and the expectations in respect of their reports. This guidance included a detailed consideration of the Terms of Reference, and the need for reports to focus on the lessons for the agency and any missed opportunities in the case. The event was used as an opportunity for all the agencies involved to share their chronologies with each other, in order for the information held not to be seen in isolation, and for the IMR authors to check if any information was missing or not available in their records. Feedback from those present was that this was a helpful exercise in helping them to consider the actions of their agencies with Child B and the family in an interagency and safeguarding systems context. This increased the potential learning for the agencies involved.

3.6 The first drafts of the IMRs were received over a period of months, due to the delay in receiving permission from West Mercia Police to interview staff. This was due to a number of
members of staff across agencies who were being interviewed by the Police with regard to the on-
going criminal investigation. It was only when the statements had been taken, then signed by
witnesses, that it was possible to interview staff for this parallel process. A chart is available below
at 4.7 with details of the dates that IMRs were received. All staff were interviewed by the time that
the first draft of this overview report was completed in April 2013.

3.7 A number of the IMRs were returned to authors for changes to be made, due to either quality
concerns or because further information was required. There was also a need for a number of the
Action Plans to be reconsidered to ensure they appropriately reflected the agencies learning and
that they were SMART (specific, measurable, attainable, relevant and timely) and suitable for
purpose. Clear guidance was given to all agencies to confirm that it is not necessary to await the
outcome of this Serious Case Review before implementing any changes to procedures or practice
that have been indicated by their internal enquiries. The Serious Case Review Panel (SCRP) has
continued to scrutinise the timescales in the relevant Action Plans and it can be confirmed that all
agencies have taken action to implement their recommendations.

3.8 In compiling the Overview Report, the author accessed various research documents and
procedural guidance which are referenced throughout.

3.9 TWSCB are acutely aware of the importance of incorporating the views of family members
into this Serious Case Review process, however the ongoing criminal investigation delayed any
attempt to engage with them at an early stage (see Section 6). It was the intention of the panel to
speak to the family before this report was completed and published; however, attempts made in
May 2015 to speak to both Mother and Father were refused by both parents.

3.10 As well as the criminal investigation, the Coroner undertook parallel enquiries into the death
of Child B, with the inquest being opened on 07 September 2012, adjourned initially until 30
November 2012 and then adjourned again. No further inquest will take place due to the result of the
criminal investigation and convictions.

3.11 This Overview Report was presented to a special meeting of TWSCB on 30 July 2013 where
it was adopted by the Board and a commitment made to implement the recommendations. It was
agreed at that meeting that when the criminal investigation was completed there would be
engagement with the family and any additional learning would be included in the report prior to
publication. Unfortunately, neither parent responded to extensive attempts to speak with them in
April and May 2015.

3.12 Working Together Guidance 2010 (Paragraph 8.5) requires LSCBs to establish Serious
Case Review Panels to undertake the Review. It is a requirement that this panel is chaired by
someone who is not a member of the Safeguarding Children Board involved, or an employee of any
of the agencies involved. There must also be a separate and independent Overview Report writer.

3.13 The Independent Chair appointed for this Serious Case Review Panel is Claire Porter, who
is the Corporate Head of Legal and Democratic Services for Shropshire Council. Telford & Wrekin
and Shropshire have a reciprocal arrangement to chair each other’s panels if a SCR is required.
She has significant experience in undertaking Serious Case Reviews either as author or Chairing
panels for nearly two decades. Ms Porter is the Chief Solicitor at Shropshire Council, a role that she
has held for 16 years. She started her legal career as a child care advocate. Ms Porter is
independent of the case and is not employed by any of the agencies represented on TWSCB.
3.14 The author of the Overview Report, Nicki Pettitt, is an Independent Social Work Consultant. Ms Pettitt has 26 years' post qualifying experience, the majority of which she has spent employed by local authorities Children's Services in London and the South East, including as a senior manager with responsibility for child protection. She is an experienced author of both Individual Management Reviews and Overview Reports and has chaired a number of Serious Case Reviews. Ms Pettitt is independent of all agencies represented on TWSCB.

3.15 Working Together (2010) requires that the members of the Panel as nominated by local agencies should be identified in this report only by their designation and agency. For this Serious Case Review the Panel members are listed below:

- Assistant Director, Children’s Safeguarding, Telford and Wrekin (T&W) Council
- Head of Service, West Mercia Probation Trust
- Detective Inspector Public Protection, West Mercia Police
- Service Delivery Manager, T&W Safeguarding Advisory Service
- Consultant Paediatrician /Designated Doctor, Shropshire Community Health Trust (SCHT)
- Designated Nurse for Safeguarding, Shropshire, Telford and Wrekin Primary Care Trust (PCT)/ Clinical Commissioning Group (CCG)
- Deputy Chief Nurse, Shrewsbury and Telford Hospital National Health Service (NHS) Trust (SaTH)
- Director of Quality and Safety/Chief Nurse – Shrewsbury & Telford Hospital NHS Trust.

The Service Delivery Specialist – T&W Corporate Parenting, Education, Skills and Culture, was available to the panel as required and attended four of the panel meetings as consultant to the process.

3.16 In order to carry out its function of managing the process and quality assuring reports, the Serious Case Review Panel met on the following occasions:

- 12 November 2012
- 12 December 2012
- 29 January 2013
- 19 February 2013
- 20 March 2013
- 29 April 2013
- 15 May 2013
- 19 June 2013

Administrative support was provided by the TWSCB. A record was made of each meeting and a list of tasks to be completed was maintained and updated at each meeting. There was a good commitment to meetings and actions were completed with minimal delay.

4 INDIVIDUAL MANAGEMENT REVIEWS (IMRs)

4.1 On 11 October 2012 the Chair of the TWSCB wrote to all agencies advising them of the decision to undertake a Serious Case Review and requesting that all agencies research their records relating to the family and initially complete a chronology of their involvement and a brief summary of what was known about the family by their agency. This was to be submitted by 01 November 2012.
4.2 On 12 November 2012 the full panel met with the overview author and all IMR authors were invited to attend, so that they could share their chronologies and receive advice and support in relation to completing their IMRs. This was a helpful session where an integrated chronology was compiled on flip-charts around the room, focusing on significant events (those where something happened that could/should be discussed/shared with other agencies) and all IMR authors were able to discuss their agency’s role alongside other agencies. This enabled the panel and IMR authors to identify gaps in information and communication and to begin to identify some of the lessons to be learned.

4.3 Agencies were required to look critically and openly at individual and organisational practice to ascertain whether changes could and should be made and, if so, how this should be achieved. It was a requirement that a designated senior manager who had no previous involvement or line management responsibility for the case should complete the individual reviews, and the Serious Case Review Panel are satisfied that this standard has been complied with by all agencies.

4.4 Guidance notes with a template were provided to all agencies, including a requirement for them to implement any recommendations arising from the review in a timely way. Agencies were required to send a nil return if they could find no trace of involvement with the family. To assist agencies in drafting their IMR, the letter also included an updated guidance on completing IMRs and a template for the Action Plan and the Chronology.

4.5 In this Serious Case Review IMRs or other reports were received from the following Telford and Wrekin agencies. After being considered by the panel a number were asked to provide clarifications and later versions as follows:

<table>
<thead>
<tr>
<th>IMR</th>
<th>Version received 1</th>
<th>Version received 2</th>
<th>Version received 3</th>
<th>Version received 4</th>
<th>Signed off</th>
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</thead>
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<td>21 January 2013</td>
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<td>29 January 2013</td>
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</tr>
<tr>
<td>West Midlands Ambulance Service</td>
<td>7 December 2012</td>
<td>21 January 2013</td>
<td>Not applicable</td>
<td>29 January 2013</td>
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</tr>
<tr>
<td>CCG</td>
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<td>16 January 2013</td>
<td>15 February 2013</td>
<td>20 March 2013</td>
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<tr>
<td>Shropshire Community Health NHS Trust</td>
<td>4 December 2012</td>
<td>22 January 2013</td>
<td>20 February 2013</td>
<td>25 April 2013</td>
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</tr>
<tr>
<td>Birmingham Childrens Hospital</td>
<td>12 December 2012</td>
<td>20 February 2013</td>
<td>Not applicable</td>
<td>20 March 2013</td>
<td></td>
</tr>
<tr>
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<td>11 December 2012</td>
<td>28 January 2013</td>
<td>19 March 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Mercia Police</td>
<td>21 January 2013</td>
<td>15 February 2013</td>
<td>17 April 2013</td>
<td>Not applicable</td>
<td>29 April 2013</td>
</tr>
<tr>
<td>Bromford Housing</td>
<td>7 December 2012</td>
<td>21 January 2013</td>
<td>13 February 2013</td>
<td>16 April 2013</td>
<td>29 April 2013</td>
</tr>
</tbody>
</table>
Stay  |  7 December 2012 | 22 January 2013 | 12 February 2013 | 12 March 2013  
--- | --- | --- | --- | ---  
Nursery  | 14 February 2013 | 15 March 2013 | 25 April 2013 | Not applicable | 29 April 2013

4.6 Since March 2010 it has been a procedural requirement for a Health Overview report to be completed in all Serious Case Reviews. This report, which in this review has been completed jointly by the Designated Nurse and the Designated Doctor for safeguarding children and young people, focuses on how health organisations have interacted together and makes it own recommendations for the commissioners of health services in the TWSCB area.

4.7 Written confirmation that agencies had no contact with Child B or the family (nil returns) were received from West Mercia Probation and from South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

4.8 It is a requirement of TWSCB procedures that all IMRs produced by partner agencies for a Serious Case Review are ‘signed off’ by a Senior Manager within that agency. This is confirmation that the report is accurate and of good quality, that the agency fully accepts its findings and that all recommendations contained within the IMR will be subject to timely implementation.

5 FAMILY INVOLVEMENT

5.1 TWSCB, the Serious Case Review Panel and the author are fully committed to facilitating the participation of relevant family members in this Serious Case Review, believing that their knowledge and views can considerably enhance the learning from this process.

5.2 The Serious Case Review Panel has addressed this issue systematically using the following framework:
   - Are there any known factors which may affect the involvement of any family members?
   - Which family members will be asked to contribute and why?
   - Are there issues around timing which may affect this dialogue?
   - Who will be responsible for supporting family members involved?
   - What resources will be required to facilitate this process?

5.3 The Serious Case Review Panel agreed that the relevant persons who would be invited to contribute to this review were the Mother and Father.

5.4 The panel agreed, after consultation with the senior investigating officer in West Mercia Police, that it was important to avoid compromising any current criminal proceedings relating to the death of the child. In this case it is felt to be important that no direct contact be made until after the police investigation had been completed. It was the intention to meet with both parents before the Serious Case Review is completed, and to incorporate information received from them into this report. The Independent Author made contact with Mother at her home address and Father in prison after they were sentenced for their part in the death of Child B. Mother did not respond to either letter and Father refused to see the author and a member of the TWSCB when they visited him in prison.
5.5 Both parents have since been informed in writing that the full Overview Report will be published on the TWSCB website, and that every possible care will be taken to safeguard their identity. They were informed however that given the circumstances of this case and the media attention at the time of the trial, this may be impossible to achieve.

6. CULTURAL CONSIDERATIONS

6.1 In this case Child B and their family are white British. Their only language is English. This information appears to have been accurately recorded on agency records.

6.2 No agencies have a record of the family practising any religion, however it is recorded that Child B was christened in hospital in the days before death.

6.3 Child B was born to a teenage mother, who was not living with her parents or extended family when her baby was born. Without the opportunity to engage with the family, it has not been possible to gain additional information about both parents' childhood experiences. The SATH IMR states that hospital records show that the mother's surname is the third one that she has had in her relatively short life. How significant this is was on the agenda for discussion with Mother when we met her. However this was not possible before publication.

6.4 After a period staying with family and friends, then in temporary accommodation at the latter stages of the pregnancy and when Child B was born, Child B and their Mother moved into a rented flat with a secure tenancy around a month before the death of the child. It is significant that this was a very young single mother, with a history of unstable accommodation, who appears to have been receiving very little support from either family or professionals throughout the majority of the timeframe of the review.

6.5 Neither parent nor their wider families appear to have been well known to any agencies as children or young adults. Both parents were known to the police. Father was a victim in six incidents from 2004 – 2008, and none of these incidents were of significance to this review. Mother as the perpetrator of two counts of ‘common assault by beating’ in 2008, none of these were in relation to Father. One of the incidents was racially motivated and when Mother was said to be under the influence of alcohol. Neither matter was pursued by the Police/Crown Prosecution Service (CPS).

6.6 The area where Mother and Child B lived at the time of the child's death is described as predominantly White British by the housing provider.

7 FAMILY COMPOSITION

7.1 Child B always lived with Mother and, in the latter part of the child’s life, Father appears to have also been resident in the family home. The IMR for the child care provider clarifies that Child B’s parents met only a few months before she fell pregnant. It was the understanding of the child care manager that the relationship was not particularly stable. It is noted that Father is around 8 years older than Mother.

7.2 The relationship between the parents appears to have continued to be unstable after the pregnancy, with midwives being informed by Mother that Child B’s father was not involved. There is no record that the father was present at the time of Child B’s birth. Despite this, Father’s details were recorded clearly on the midwives paperwork, which is good practice. At the time of Child B’s death Father was living with his partner and Child B. IMRs lead us to the conclusion that Mother and
Father were living together from around 2 months before Child B died. As we have not spoken to the family as part of this review, we have been unable to establish what support Child B’s mother was receiving from the family during her pregnancy and after Child B's birth, or the status of her relationship with Child B’s father throughout the timeframe of this SCR.

7.3 Members of both extended families appeared to live near to Child B’s home, notably maternal grandmother and her partner, maternal aunt and maternal great-aunt, and paternal grandparents. None of the agencies involved with Child B and the family have extensive information about the wider family or the childhood experiences of the parents.

8 CHRONOLOGICAL SEQUENCE OF EVENTS

8.1 A multi-agency chronology has been prepared, detailing extensively the involvement of all agencies with the subject child and family. The following is a summary of involvement, focusing on the events that the Serious Case Review Panel considers to be the most relevant in the context of this review, and those that provide learning for the agencies involved.

8.2 Child B was born in 2011 to a young mother who appeared to be estranged from her own parents. She was living in supported accommodation and was bidding for re-housing in the area where she had grown up. At her pregnancy booking with the midwife at 12 weeks, Mother stated she was well supported by her boyfriend, and was living with her sister.

8.3 Mother was referred to the Teenage Identified Midwives (TIMs), who provide first time teenage mothers with a targeted level of support during their pregnancy. She was on the ‘high risk pathway’ which should provide additional home visits by the midwives and continued checks on what support Mother was receiving. Mother worked full-time in a child care setting, and no concerns were noted during the pregnancy by the midwives involved, and no additional support was recommended.

8.4 When she was seen at a 25 week ante-natal check Mother told the midwife she was now living with her aunt and was hoping to move into supported accommodation. She moved into this planned accommodation when she was around 28 weeks pregnant.

8.5 Child B was delivered at 39 weeks after a relatively uneventful pregnancy and a normal birth with no complications. Mother and Child B were discharged home the same day.

8.6 Two weeks after Child B was born it was noted by the housing support staff that Child B’s father was visiting twice a week, and that Mother was coping well. The midwifery service discharged Mother at 15 days after the birth, and made a note that Mother stated she did not have a boyfriend.

8.7 Mother had regular key work sessions from the supported accommodation provider over the next few months. There were no concerns recorded about Child B or her parenting. Mother had some difficulties with other residents, and received a verbal warning letter for tenancy breaches on ‘overcrowding and nuisance’. It is not clear who was staying with Mother to create the overcrowding. (Recording is a recurring issue in this case and it is an issue that will be considered in the analysis below). Towards the end of her time in the supported housing accommodation Mother told staff she had reconciled with Father, and staff suspected he may have stayed, unauthorised, on occasion.
8.8 The same agency IMR also states that at this time Mother had fallen out with her aunt and was seeing her mother again. However, lack of detailed recording from health professionals or the supported housing organisation means that little is known about what help and support Mother had in the months after the birth of Child B.

8.9 Child B was predominantly healthy and received all of its inoculations. A hearing test was initially problematic, but was repeated and there were no concerns. Some issues with constipation and related weight loss were evident in the early months. Child B also reportedly had chicken pox when 5 months old, according to the supported housing records. There is no medical record of this however.

8.10 When Child B was 6 months old, the Health Visitor noted in the parent held child health record (red book) that Child B had some facial bruising. Mother explained this was self-inflicted, from Child B head butting toys and banging toys on their face. Child B was said to be rolling over at this stage but not yet sitting. The Health Visitor recorded that she would arrange to go and review Child B’s development in the following weeks. There is no record that this happened.

8.11 When Child B was 9 months old Mother was given the tenancy to her own property. It was in Mother’s sole name, and she advised that just she and child B would be living at the property. She was also given permission to keep a dog. It is not known if Mother was in receipt of any benefits.

8.12 At around the same time Mother returned to work Child B went with her as the plan was for the child to attend the same child care provider four days a week, spending the other day in the care of family members. Mother lived and worked in the same area.

8.13 Later the same month Mother attended her GP surgery and saw the practice nurse, as Child B had a small purple mark on the ear. When asked, Mother had no explanation for the bruise, which was accompanied by a small graze. Mother was advised ‘to observe’. There is no record that the GP was consulted or that the possibility of safeguarding concerns were considered.

8.14 The following week both parents brought Child B to the emergency department of their local hospital. Child B had reportedly awoken from sleep screaming, and parents noted a lump on the back of the head which wasn’t there when Child B was put to bed that night. They reported that the lump appeared to be tender. Child B was seen by a locum registrar who documented that a thorough examination of Child B was undertaken and that there was ‘no evidence of NAI’ (Non Accidental Injury). The lump was felt to be a normal prominence of a baby’s head, and Child B was discharged. The Doctor still gave head injury advice to parents and also communicated with Child B’s health visitor to follow up the child. This was felt by the IMR author and the Health Overview authors to be the appropriate advice. However the Doctor did not then consult a Paediatrician which is what is recommended by the guidance from The Royal College of Paediatrics and Child Health (2012) with any child under six months with a head injury.

8.15 Soon afterwards Mother had telephone contact with the Practice Nurse at the GP surgery to tell them that Child B was suffering from intermittent swelling of the occiput (back of the head) which had lasted 4 to 5 months and that Child B had been seen in A&E. Mother reported that no action was to be taken as the swelling settled “sporadically”. Mother requested a review so an appointment was made to see the GP the next day. The appointment was defaulted. There is no evidence within the GP records of any further advice being sought regarding the swelling or of any follow-up by the GP or Practice Nurse.
8.16 Around three weeks later Child B was brought to the emergency department of the same hospital by Mother and Father, who had not been able to get a GP appointment. They reported that Child B had been sick (vomiting) for three days. Child B was also noted to have ‘streaks of petechial’ non blanching rash’ over the right side of the neck, and some possible bruising on the back and thigh. Father said other marks on the back were from when Child B had chicken pox.

8.17 Child B was seen by a number of doctors. The first filled out a safeguarding form but stated the bruises and marks were ‘not non-accidental’. Another doctor who saw the child later had recorded ‘NAI’, which appears to be questioning if the injuries could be non-accidental. The following day the child was seen by a consultant who recorded ‘tiny bruises on bony prominence of back – look like due active playing’ as Mother had said that Child B was a very active child who rolled onto toys. (She hadn’t mentioned this the night before, stating she had forgotten as she was stressed by the hospital admission.) He also recorded that the petechial rash on the neck was ‘possibly due to vomiting’ and the petechial spots were ‘possibly chicken pox rash’. Child B, who was 10 months old at this stage, was discharged later that day.

8.18 The discharge letter to the GP documented a diagnosis of viral illness. It did not mention any bruising or any concerns for child B but did refer to a “petechial non blanching rash”. There was no recorded action for the GP.

8.19 Child B was back at the same hospital 2 days later as the parents were still concerned about vomiting. The child was admitted and observed, and discharged home 24 hours later.

8.20 The following week, and around three weeks before Child B died, a call was made to the GP ‘out of hours’ service during the evening. It was reported that Child B had been vomiting for 13 days approximately 1 to 3 times daily. They were advised to present at the out of hours GP clinic. Mother telephoned them, but they agreed she should take Child B to the GP the following day.

8.21 The GP referred to the hospital again, due to the further vomiting. There were issues in A&E so Child B was seen on the children’s ward. Child B was recorded as looking tired and had a small bruise on the right lower eyelid. Child B was admitted to the ward for observation of feeding and further investigations. Mother was asked about the bruise to the right eye, and said that Child B was hit by the dog’s tail. On examination 2 other bruises were noted on the legs of Child B, which Mother reported were due to the baby sticking its legs through the bars of the cot. According to the nursing notes, Child B’s maternal grandmother was also present on the ward during the day.

8.22 The doctor reported that Mother was completely clear and consistent in her account that Child B had been hit by the tail of the family dog, and that she had said that the child had cried briefly and the bruise was noted the following day. The doctor reportedly considered this at some length and ascertained that the particular breed of dog has a thick tail without a lot of fur and that it was plausible as a cause of the bruise. There was also acceptance that the other bruises could be caused by the bars of the cot. It is noted that the previous bruising and petechiae were gone, and there was a discussion with the consultant who had previously seen Child B, who again stated that they were sure that the previous petechiae were in a distribution that could be explained by vomiting. A social care check had confirmed that the family were not known to social workers.

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¹ a tiny purplish-red spot on the skin caused by the release into the skin of a very small quantity of blood from a capillary.
8.23  During the next week Mother spoke to the Health Visitor, who had decided to call because a community nursery nurse who was asked to visit had not been successful in her attempts to visit Child B. Mother had explained that Child B attended child care and agreed to see the community nursery nurse who liaises with the child care provider if required. Mother also had a discussion with the practice nurse at the GP surgery regarding on-going concerns about Child B vomiting. The Practice Nurse then liaised with the GP who recommended Child B be fed with soya milk, to try to assist with the reported vomiting.

8.24  After an initial period where the child attended the child care provider regularly, both Child B and Mother had a lot of time off, due to Child B’s vomiting illness. In the last month of its life Child B missed 12 of a possible 19 days of child care. On Child B’s last day there, and 4 days before being taken to hospital by ambulance, the child was reported by staff to have been violently sick and was observed to be warm although not crying. For the next three days Child B’s mother sent a text to the Manager to inform her that Child B was still sick.

8.25  The day before the child was admitted with a cardiac arrest, Mother telephoned the GP surgery and spoke to the Practice Nurse. Child B’s vomiting was reported to have returned 2 days previously. The child was reportedly not eating and was floppy and lethargic. An appointment was made with the GP for later that day. On examination Child B was reported to be vomiting 3 to 4 times per day. Temperature, saturations and other clinical checks were normal. The GP planned to treat the condition as a further viral illness and review Child B after 24 to 36 hours if there were no signs of improvement.

8.26  The next evening, the parents called an ambulance at 19.02 as Child B was not breathing. The ambulance arrived at 19.06. They gave basic life support and the child was transported to the local hospital under blue light conditions. Shortly after arrival at Hospital 1 it was decided to transfer Child B to the regional specialist hospital, Hospital 2.

8.27  As is the usual practice by TWSCB, the terms of reference for this SCR were extended beyond the incident that led to the death of the child, due to a desire to understand what happened in the course of the child protection investigation following the child’s arrival at hospital.

8.28  The police were called by Hospital 1 and attended hospital, they then followed the ambulance to the specialist hospital (Hospital 2) when Child B was transferred.

8.29  The Children’s Social Care (CSC) Emergency Duty Team Senior Social Worker (EDS SSW) was informed by Hospital 1 of the serious situation when the hospital rang to check if the child and family were known to CSC. The incident happened on a Friday evening, so the majority of work was undertaken by out of hours services and the senior social workers from the Emergency Duty Team. There were concerns identified about transfer of information and the way that the investigation was managed over the weekend. Two strategy meetings were held, chaired by the Police Chief Inspector. It has been identified that there were issues about the status, the chairing and the recording of these meetings and this will be considered below in the lessons to be learned section of this report.

8.30  Hospital staff at Hospital 2 ensured they clarified with the Police the appropriate contact between Child B and family members after the arrest of both parents.
8.31 Responsibility for Child B and the child protection investigation transferred to the responsible team on Monday morning, with the EDS SSW going to the office to meet with staff to ensure there was a suitable exchange of information.

8.32 The decision to withdraw life support was made on the Tuesday and Child B died shortly afterwards.

8.33 A Position of Trust strategy meeting was held to consider Mother’s job in a child care setting. The decision to hold one of these meetings is made by the LADO (Local Authority Designated Officer) who also chairs the meeting. The meeting agreed that Mother should be suspended from work until the result of the criminal investigation was established. She remained suspended throughout the time that it took to complete this review. Continued employment in such a setting is unlikely to be compatible with Mother’s conviction.

9 ANALYSIS

9.1 This section of the Overview Report will consider ‘how and why events occurred, decisions were made and actions taken or not taken’ (Working Together 2010). The analysis will also state the views of the SCR panel regarding whether different decisions or actions may have led to an alternative course of events.

9.2 To achieve this, the section will be divided into two parts:
   1. Summary of the agencies’ responses to the Terms of Reference established for this Review, incorporating the panel and authors analysis of the responses.
   2. A themed analysis of the key events and decision making in this case, including any examples of good practice highlighted by agencies in their IMRs.

9.3 Terms of Reference:

Were practitioners aware of and sensitive to the needs of children in their work, and knowledgeable both about potential indicators of abuse or neglect and what to do if they had concerns about a child’s welfare?

9.4 The majority of IMRs addressed the specific questions directly. Most felt that staff were both aware of and sensitive to the needs of children, and aware of the procedures to follow. However there was some acknowledgement that staff at the hospital, the GP surgery and the Health Visitor did not adequately consider if the presence of bruises in a non-mobile child could be a sign of child abuse. As the report written by an independent expert, requested by the Hospital 1 IMR author states, there was a ‘lack of understanding by professionals around the significance of bruising in children not independently mobile’. The same report outlines the research available and is clear that bruising is very uncommon in non-independently mobile infants. The report states ‘in abused children, bruises tend to occur away from bony prominences, the commonest site being the neck, ear and cheeks, buttocks, trunk, and arms. Petechial bruising is also more common in abusive injuries’. These type of bruises were evident in Child B’s case on a number of occasions.

9.5 The child attended a day care setting from 7 months old. Mother was employed by the same organisation. This meant Child B spent its time in child care actually in the care of its Mother. It is clear from the IMR that this had an impact on the way that Child B was seen by other staff and in the way the child’s time there was both recorded and monitored. On one occasion the child was said
to have fallen from a staff member’s lap onto the floor. The incident form was signed by Mother as both the staff member and the parent. There does not appear to be an independent witness of this fall, and no staff member questioned remembers it. The form completed by Mother does not name another staff member. This is clearly not good practice, did not follow procedures, and was not in the best interests of Child B.

When, and in what way, were the child’s wishes and feelings ascertained and taken account of when making decisions about the provision of children’s services? Was this information recorded?

9.6 As a young baby, it is obvious that Child B could not be spoken to about what may have been happening at home. Questions were asked of both Mother and Father about the cause of bruises, and their explanation recorded. However, there does not appear to be much consideration given to Child B’s development, or any observations of the relationship between child and parents, or the parent’s relationship with each other.

9.7 After Child B was admitted to Hospital 2 with life threatening injuries, the child’s welfare was considered with regard to contact with the parents. Multi-agency consideration and liaison about the risks parents may pose to Child B was evident, and a plan put in place. The police and EDT Senior Social Worker immediately considered if there were other children in the family when they received the referral.

Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

9.8 All of the agencies who contributed to this review have safeguarding policy and procedures in place. These procedures are said to be available to all staff. As Child B was not considered a child potentially at risk at any stage before the night that the serious injuries were identified, the presence of these procedures did not have an impact.

What were the relevant points/opportunities for assessment and decision-making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

9.9 When Mother became pregnant there was an opportunity to find out about the support she would be likely to receive during her pregnancy and after the birth of her child, and to consider if there may be any additional needs in relation to her parenting. Mother was 17 years old and was not living with her own family when Child B was born. Recognising that she had a job as a child care professional appears to have led the health and supported housing staff to the conclusion that she would have the appropriate skills and support in place to ensure appropriate parenting. This was an assumption that was flawed and overly optimistic. There was a distinct lack of professional curiosity when it came to exploring the experience and support this very young mother had.

9.10 The IMR for the supported housing organisation states that staff did not record the reason for Mother being estranged from her family and partner and why she was living alone while pregnant. In interviews undertaken by the IMR author staff were clear that Mother and Maternal Grandmother’s relationship had broken down, and that Mother could no longer live with her aunt as there was an issue of overcrowding. These facts were accepted, and no questions were asked about the impact of her isolation from her Mother on her becoming a parent herself. A needs assessment was
completed within 6 weeks of moving into the accommodation, and the IMR author points out that although completed it was not signed by Mother and would have benefitted from more information. The support plans that were then formulated for both Mother and for Child B were limited and not reviewed as regularly as is required in the agencies procedures. In the case of Child B’s support plan, which was also written and is part of the agencies procedures, it does not appear to have been reviewed at all.

9.11 When Mother was receiving regular key work sessions with staff in the supported housing organisation, there was a further opportunity to explore any potential issues for this mother who was soon to be living independently with a young baby, there is no evidence that this opportunity was taken. The sessions happened, but record keeping was poor and the content of the sessions was not clear. The lack of any meaningful assessment and support was a missed opportunity.

9.12 An exit review was the final, formal opportunity for the supported housing staff to assess whether Mother had sufficient life skills and confidence to move on to independent living with her baby. The assessment concluded that she was able to live independently, therefore the recommendation was made, and a reference provided to the housing association that re-housed Mother and Child B. The IMR states that the exit review was not attended or signed off by a senior manager, as is the policy and procedure.

9.13 When mother moved with Child B into her own housing, there was again an opportunity for an assessment of Mothers need for support to be made by the housing association. This was not taken, with the relevant IMR stating that as no issues had been identified about Mothers parenting, and no concerns expressed about Mother or Child B, they did not need to undertake any assessment.

9.14 The IMR author for the CCG states that as Mother was only 17 at the time of her pregnancy with Child B, and she did not appear to have parental support and was living alone, a pre-birth assessment or CAF should have been considered during the pregnancy. These would have assessed her level of need in order to determine the level of support required. She also notes that there was no referral made to the Family Nurse Partnership (FNP) Programme, which is a preventive programme for young first time mothers which offers intensive and structured home visiting, delivered by specially trained family nurses from early pregnancy until the child is aged two. It has been established that at the time of Mother’s pregnancy referrals to the programme were closed, due to over capacity. However, there does not appear to have been any consideration given to referring to this project, and it was not recorded that this was an unmet need. It has been concluded that Mother’s job as a child care worker may have led to the assumption that any additional support with her parenting was not required. Indeed, there were never any concerns raised about her practical care of Child B, the baby’s routines, or the physical environment where they lived. It is therefore questionable whether Mother would have been prioritised for the FNP had there been an opportunity for referral, with the superficial information held on her by universal health providers.

9.15 There was a missed opportunity for a more in-depth consideration of Child B’s care and Mother’s ability to cope when the Health Visitor noticed bruising on Child B’s face, which Mother said was self-inflicted, caused by Child B hitting its own face with toys. However the mark was simply noted in the parent held record and Mother was asked to observe.
9.16 A further missed opportunity for assessment was when the Practice Nurse at the GP surgery noted a bruise on the child's ear, which Mother had no explanation for. This injury should have prompted a discussion with the GP, followed by the safeguarding lead and communication with children's social care. It should also have led to liaison between the Practice Nurse and Health Visitor to ensure appropriate information was shared and any concerns determined. It was felt that the bruise was possibly the result of an injury; however no further action was taken and it is documented that the mark was a possible injury and “to observe”. There is no documentation regarding who was to observe the bruise, when and how and what action was to be taken. There is no evidence of a discussion with anyone else and no reported contact with Children's Social Care.

9.17 When Child B had bruises, as seen on 4 separate occasions by the Health Visitor, the Practice Nurse, and a number of doctors at Hospital 1, there was a need for more questions to be asked, and opinions to be sought, to establish if the injuries were non-accidental. All of these injuries, in their own right, should have resulted in a further assessment and a conversation with the relevant safeguarding lead. As stated in the CCG IMR ‘healthcare staff need to assess risk based on site and type of injury, stage of development of the child and explanation offered by the parent in order to ensure that chances to safeguard children are not missed and to ensure that timely intervention prevents further abuse’.

Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made in the light of assessments?

9.18 As established above, there were very few assessments undertaken with regard to Mother, and none with regard to the parenting of Child B. There were also no assessments undertaken or even considered in relation to Father, although a number of agencies knew or assumed he was living with Child B at the time of the injuries.

9.20 There is very little evidence of communication between professionals in relation to Child B. An opportunity for this included the exit review from the supported accommodation to independent housing. The IMR states it is usual to invite other agencies to this meeting, for example a health visitor, but that in this case none came and it is not recorded if any were invited. There was also lack of communication between health agencies when Child B presented to the clinic, the surgery and the hospital and bruises were noted. Letters were sent to the GP after the hospital admissions, but these did not always include all the information. For example, the discharge letter sent regarding the second admission, where bruises were noted on Child B, detailed a viral illness and a “petechial non blanching rash’. It did not mention any bruising or any concerns for Child B.

Were there any issues in communication, information sharing or service delivery, between those with responsibility for working during normal office hours and others providing out of hours services?

9.21 The child protection issues were identified after the parents called an ambulance on a Friday evening, and most of the child protection investigation was undertaken outside of normal office hours, by the Council EDT (Emergency Duty Team) senior social workers and the police on-call detective sergeant.

9.22 Hospital 1 referred to the Police and EDT nearly 4 hours after the initial call to the ambulance. The ambulance service did not contact the Police on this occasion. The Police attended immediately, but they did not refer to the EDT. The hospital did this however and the EDT senior social worker ensured she spoke to the Police immediately to check the details of the family,
(the hospital computers were not able to provide the required information as there was a technical issue with the system) and to check if there were other children in the family. The Social Care IMR states that initially the wrong family details were given, which hindered checks on the family's records being undertaken correctly.

9.23 There was clearly some confusion on the evening of Child B’s admission to hospital, which it has been hard for the Police panel member to explore fully and comment on, due to the Police Officers who attended being unable to remember the details. It is clear however that the difficulties, while being frustrating for the social worker on duty, did not hinder the investigation or result in any children being at risk in this case. In another case, where there may be siblings, this could be a concern. It was not until the next morning that the EDT SSW was able to confirm all the details and check that the family were not previously known to social care.

9.24 Two strategy meetings were held over the weekend, but it is not clear if the status of those meetings were confirmed to all who attended, and whether the checklist provided on the Telford and Wrekin on-line procedures was used. However, the IMR received from Hospital 2 states that the strategy meeting was attended by the key hospital personnel: these were the Named Consultant Paediatrician, the Consultant in Paediatric Intensive Care and the Named Nurse for Child Protection, and that they recorded the key points of discussion immediately afterwards, as is expected practice.

9.25 Both meetings were chaired by a Police Inspector, which is unusual, but as the EDT SSW had not informed the Service Delivery Manager in children’s social care, it appears to have been agreed that the Inspector was best placed to chair the meeting. It was recorded by the EDT SSW that the minutes of the meetings would be shared with Children’s Social Care and health agencies present.

9.26 The purpose of a Strategy meeting/discussion is to:
- Share information between all appropriate agencies when there is reason to believe that a child is at risk of significant harm or has been harmed
- Decide whether there are sufficient concerns to warrant a child protection investigation (Section 47 Children Act 1989)
- Decide the format of the investigation and agree areas of responsibility for each agency, representative
- Plan how enquiries should be handled, including the need for medical treatment and by whom
- Agree what action is needed immediately to safeguard the child and / or provide interim services and support
- Determine what information about these Strategy discussion will be shared with the family, unless such information sharing may place a child at risk of significant harm or jeopardise police investigations into any alleged offences

9.27 It appears that the majority of the factors above were considered in the meetings and the IMR received from Hospital 2 states that the child was safeguarded and the investigation was undertaken in a positive and sensitive way by all staff involved.

9.28 A ‘professionals meeting’ was held the following week, which appears to have been chaired by the Social Worker recently allocated to the case. It was not clear to the Social Worker who attended what the status or remit of this meeting was, but it was requested by the staff at Hospital 2.
There is no reference to this meeting in any of the other IMRs or chronologies, so it is not clear if any minutes were made and circulated. The chronology states that agreements were made at the meeting regarding Child B's on-going medical care, the securing of medical evidence and contact arrangements for Baby B and the parents. What is clear is that it was not appropriate for a social worker to chair this meeting, and that the status, purpose and plans for recording the meeting should have been clarified in advance.

Where relevant, were appropriate Child Protection or Care Plans in place, and Child Protection and/or Looked After Reviewing processes complied with?

9.29 Prior to the night that Child B was taken to hospital with fatal injuries Child B was never subject to a child protection investigation or a child protection conference, and Child B was not a looked after child. Child B was never identified as a child in need of any additional assessment or support. On the four occasions when the child was seen to have bruises, consideration should have been given to making a referral to children's social care for an assessment/investigation.

Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

9.29 Child B and the parents were white British. They appear to have lived in the Telford and Wrekin area most of their lives and to have family living close by. All the agencies involved considered the services provided by them to be relevant and reflective of the family's racial, language and cultural needs. When Child B was in hospital and on life support, a christening was arranged at the request of the parents. This shows sensitivity to the family's religious identity.

9.30 Child B attended a private child care setting 4 days a week. As a white British, English speaking child without any identified disability or delay, Child B’s needs were typical of other children attending the child care, and reflected by the staff group.

9.31 What does appear to have been overlooked by those agencies involved with Child B was Mother's potential isolation as a young single parent, living in insecure then independent housing, without any professional or family support. It is possible that this situation is common in the area where Child B lived. Certainly when the family were living in supported housing there were a high number of other young parents living in the accommodation, and Child B and Mother had regular contact with staff. It was when Mother moved out to her own accommodation that it appears Child B became increasingly vulnerable.

9.32 The child care setting where Mother worked and Child B attended did provide security of employment for Mother. As the IMR states, they have ‘supported Child B’s mother from a Year 11 student on an alternative timetable at risk of drifting away from employment and education to a level 2 qualified child care assistant’. They also are documented as providing help and advice as required, particularly when Child B was suffering from reoccurring vomiting.

Were Senior Managers, all other organisations and professionals involved at a point in the case where they should have been?
9.33 On the two occasions that bruising was seen on Child B, by the health visitor and the practice nurse, there was no consultation with any other professionals or with managers or supervisors. In the case of the health visitor, the IMR author was only aware of the bruising when she looked at the child's parental held health records (the Red Book). The panel have been informed that this matter is being taken up with this member of staff by their managers.

9.34 There was a lack of consideration of talking to the named/designated safeguarding leads by hospital staff on the occasions that Child B was taken to hospital and bruising was seen. At Hospital 1 non accidental injury was suspected by the paediatric associate specialist, but this was dismissed by the Consultant Paediatrician the following day. This difference of opinion should have resulted in a discussion with the named doctor for safeguarding prior to discharge home, as this is what is required in the hospital’s safeguarding protocol.

9.35 When Child B was taken to hospital by ambulance there was some delay in both the Police and EDT being informed of the child’s serious injuries. Over the weekend the EDT SSW did not inform the Service Delivery Manager of the serious incident and Child B’s life-threatening injuries. The lack of senior manager notification would not have altered the outcome for Child B; however, within a wider safeguarding perspective in different circumstances there is the potential for this lack of opportunity for senior management involvement in decision making to negatively impact on outcomes for a child.

9.36 A Position of Trust (POT) meeting was held where Mother’s employment was considered and appropriate safeguards put in place. It has since been identified that Mother had attended her workplace while children were present, which is against the recommendations of the POT meeting and her in breach of her police bail conditions. A further meeting was called where the responsibilities of the child care provider were clarified and OFSTED were informed through the process.

*Was the work in this case consistent with each organisation’s and the LSCB’s policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?*

9.37 There are concerns identified within the IMRs and from the panel that on occasion the work in this case did not protect Child B as outlined in safeguarding procedures and as would be expected as standard professional practice. Things were missed by staff at Hospital 1, by the Health Visitor, and by the Practice Nurse. When child abuse was considered on one occasion that Child B was seen in Hospital 1, the Doctor did not escalate their concerns after a colleague documented that the injuries could be non-accidental. After the death of Child B the child care provider did not adequately safeguard the children in their care by allowing Mother onto the premises, even if supervised.

*Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?*

9.39 There does not appear to have been any organisational difficulties at the time that Child B and Mother were accessing services. The FNP was not accepting any new referrals due to being over capacity at the time of Mother's pregnancy; however there does not appear to have been
consideration of referring her to the project, and it has been stated that she may not have met the threshold for support, as no support needs had been identified.

9.40 None of the IMRs received in the course of this SCR have identified vacant posts or staff absence due to sickness as having an impact on the case.

Was there sufficient management accountability for decision making?

9.41 Designated/named doctors or nurses were not consulted by any health professional who saw injuries on Child B. The EDT SSW did not inform the on-call Service Delivery Manager over the weekend that Child B was admitted with life-threatening injuries, and managers were not involved when Mother left the supported housing to go into her own property. There were also issues with the chairing of strategy meetings after Child B was seriously injured, with appropriate managers not being present and not chairing the meetings. It is the first of these issues, where designated/named doctors or nurses were not contacted however, that potentially had the most impact on the impact for Child B.

Further Specific Terms of Reference:

The IMR authors were also asked to consider the following list of questions in the body of their analysis, and this report will also consider the issues:

9.42 Focus upon the experience for child B of living in this family.

Little information was known with regard to this area as only basic assessments were undertaken and no in depth questioning and recording occurred in relation to either Mother or Child B. No further information with regard to this could be established from the parents as they did not cooperate with the author’s attempts to speak to them.

9.43 Identify lessons to be learnt and translate them into recommendations for action

This was covered in most of the IMRs and a summary of the lessons learned and the recommendations are included in this report.

9.44 Identify areas of good practice

Good practice was indentified in the IMRs; however, Working Together states that examples of good practice should relate to practice where the input of individual practitioners has been beyond the expectations of the commissioned service. The IMR for Hospital 2 states that the processes followed and the quality of care afforded to Child B by Hospital 2 was excellent. However, this SCR Panel believe that the care afforded to Child B and the parents, while good, did not go beyond what should reasonably be expected in such a case.

The SCR panel did not identify any further areas of good practice in this case.

9.45 Consider how and why events occurred, decisions were made and actions taken or not
This was a factor that was considered, to some degree, in each IMR. It is considered throughout this report, in the chronology of significant events, in the summary of the case, and in the analysis.

9.46 Identify whether different decisions or actions might have led to different consequences

The analysis section of the IMR’s, to a varying degree, considered whether different decisions or actions may have led to an alternative course of events. Although there is no guarantee, there is a probability that if health professionals had been clearer in recognising that there was no plausible explanation for the injuries, Child B would have been subjected to child protection procedures and consideration may have been given to protecting Child B by removing them from the home.

It is known that children who receive serious non-accidental injuries have often received less serious injuries previously, so called ‘sentinel’ or ‘harbinger’ injuries. A recent study (March 2013) by Dr Lynn Sheets (Children's Hospital of Wisconsin) found that of the 200 infants seen, who had definitely been abused, 27.5% had a previous sentinel injury. This was compared to none of the 101 non-abused infants, whose cases served as controls. The most common type of sentinel injury in children who were definitely abused was bruising (80%).

The research above interestingly states that medical providers were reportedly aware of sentinel injuries in 41.9% of the cases. This led the author to conclude that "detection of sentinel injuries with appropriate interventions could prevent many cases of abuse."

9.47 Identify what knowledge agencies had about the relationship between Father and the Mother

It has been identified in a number of the IMRs that all of the professionals involved with Mother and Child B did not take the time to ask and/or record the status of the relationship between Mother and Father. The lack of interest about Mother’s relationship, and the lack of questions about who the father was and what his involvement was, is one of the lessons learned in this review. It is a common lesson in a large number of SCRs.

9.48 Identify what knowledge agencies had of Mother’s teenage pregnancy and how they responded to this, and access and uptake of service

It was clear that Mother was a young parent. Information was known about her living with an aunt, then in supported housing, before moving into a property under her own tenancy. The response to this was insufficient; however, and there was little or no assessment undertaken regarding how well she would cope. Because she handled the baby well, came across positively to professionals, and worked in a childcare setting, assumptions were made about how good a parent she was likely to be.

The panel considered the issue of disguised compliance in relation to Mother. It was acknowledged that adolescents are often difficult to engage and that a pattern of partial co-operation is not unusual from teenager mother. This was certainly the case with both the supported accommodation and housing workers, and to a lesser degree the health visitor. However lack of cooperation was not enough of an issue to consider escalating the concerns.
9.49  Identify if there are any cultural issues

This has been covered above, and was considered, at least in part, in all of the IMR’s.

9.50  Consider agencies knowledge and involvement in key incidents

When Child B was seen with bruises there was little information sharing and key professionals were not consulted or informed. For example the GP was informed of the child’s admission to hospital with vomiting and the petechial rash, but was not informed of the other bruises on Child B’s back.

9.51  Consider whether a Common Assessment (CAF) / Team around the Child (TAC) should have been considered at any point during the period covered by these terms of reference

The Common Assessment Framework (CAF) is an early identification assessment of need, which ensures a standardized approach to conducting assessments of children’s additional needs and deciding how these should be met. It is used by practitioners across children's services and it is designed for use with children of all ages.

The use of a Team Around the Child (TAC) approach is designed to promote integrated working and family participation across all levels of need. They aim to improve outcomes for children and young people, and to prevent families reaching crisis point.

It is the view of the panel, the Health Overview Report (HOR) authors and a number of the IMR authors that a CAF and TAC would have been helpful when Mother, at age 16, was found to be pregnant and not living with her own mother, and had broken up from Child B’s father. How realistic it would be for a CAF to be undertaken in all of such cases in Telford and Wrekin needs consideration. Health statistics tell us that in the Telford and Wrekin area there are on average ten 16 year olds having a baby each year, and thirty 17 year olds. It is the view of the panel that a CAF could be justified in all these cases. It is however questionable whether the outcome of this CAF and a TAC approach would have made a difference to Child B.

9.51  Consider whether additional referrals to the Safeguarding Helpdesk have been considered at any point

The Safeguarding Helpdesk (now known as the Family Connect Safeguarding Advisory Team) provides the initial contact point for all agencies considering a referral to Children’s Social Care. It is clear from the IMRs that at no stage was a referral to the Safeguarding Helpdesk considered. It is clear however that the bruises seen should have at least resulted in the consideration of the need to make a referral.

9.52  Consider to what extent was the possibility of abuse considered when child B presented at the hospital for the first time.

It does not appear that the possibility of abuse was considered by any of the health professionals who saw injuries on Child B, other than the locum paediatric associate specialist who considered it on the second hospital attendance. That professional did not escalate their concerns after the disagreement was discussed, and appeared to accept the opinion of the Consultant.
9.53 Reflect upon the effectiveness of communication both within each agency and between agencies

This has been considered at 9.21 above, when addressing the Working Together 2010 terms of reference.

9.54 Refer to relevant research findings

The relevant research has been included in a number of the IMRs, in the HOR, and throughout this report. It has been particularly helpful to this process to consider the research which has been undertaken with regard to bruises in children who are not mobile.

Thematic analysis:

9.55 This section of the report will provide analysis on a thematic basis. The key themes which have emerged are as follows:

- Identification of Non Accidental Injuries in children, which take into consideration the child's development.
- Information Sharing.
- Lack of multi-agency assessment and support of a vulnerable teenage parent.
- Record Keeping.
- Lack of awareness, questioning and recording of the role of fathers.
- Professional optimism bias.

Identification of non accidental injuries in children and their developmental stage

9.56 The IMR author for Hospital 1 helpfully summarised the situation. 'There were four recorded incidents of bruising to Child B from the age of 7 to 11 months (and one possible head injury), they were facial bruising on the first occasion, a bruise to the pinna of the ear on the second, a reported head injury on the third, a number of unexplained bruises on the fourth occasion (this included a petechial rash to the right side of the neck, 2 bruises to the midline of the back, one on the lateral aspect of the thigh and one on the back of the thigh) and again one week later when bruises were noted on the right cheek and on the legs.'

9.57 It is clear that all of these injuries were in a child who was not yet independently mobile, and were considered without feasible explanations from the parents. None of them resulted in a safeguarding referral or liaison with the safeguarding leads. The first was not even recorded anywhere other than in the client held record. Diagrams/body maps were not completed in all cases to show the location of the bruises, and recording was felt to be generally poor.

9.58 The CCG IMR and the Health Overview Report provide useful analysis. They state that there were several instances where opportunities to safeguard Child B were missed. The views of the authors is that health professionals were clearly in a position to raise concerns when Child B was observed to have bruising and occipital swelling. They point out that on occasion no explanation for the bruising was given or the explanation was questionable. The following research is included in the CCG IMR: 'The NSPCC (2009) conducted a meta analysis of peer reviewed worldwide research into bruising in children. It highlighted several key messages:'
• 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 and metaphyseal) without any bruising
• The head is by far the commonest site of bruising in child abuse, as are the ears and neck
• Bruising with petechiae is more common in cases of abuse.’

9.59 If those involved in Child B’s care had been aware of this research, it is likely they would have been more vigilant in considering if the injuries could have been non-accidental and may have taken advice from safeguarding professionals.

9.60 The Hospital 1 IMR author consulted a child protection expert to consider the case and contribute to the IMR, he outlines the published evidence which indicates that ‘a petechial bruise localized to the neck in an infant is indicative of abuse, if there is no other plausible explanation’. He then takes this argument further by concluding that the acceptance by those involved of the injuries to Child B as accidental put the child at further risk, as ‘serious abuse in infants may be preceded by less severe assault in one-third, leaving apparently ‘minor’ bruising (so-called ‘harbinger’ or ‘sentinel’ injuries).’ This is certainly a possibility in this case, and was not considered by those who had direct contact with Child B in a number of health settings.

9.61 OFSTED reports on SCRs have consistently highlighted that babies less than one year have been the subject of a high proportion of serious case reviews. In a report titled ‘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.

9.62 The key themes identified in the OFSTED report are all pertinent to this review:
• The risks resulting from the parents’ own needs are underestimated, particularly
  o given the vulnerability of babies
• The shortcomings in the timeliness and quality of pre-birth assessments
• Insufficient support for young parents
• The marginalisation of the role of the father
• Need for improved assessment of, and support for, parenting capacity
• Practitioners underestimated the fragility of the baby

9.63 They also identified that there were particular lessons for both commissioning and provider health agencies, whose practitioners are often the main, or the only, agencies involved with the family in the early months.

9.64 The CCG IMR author quotes the following helpful research conclusion ‘Less than 1% of bruising to children who are not independently mobile is accidental.’ (McGuire et al 2005) A lesson from this SCR is that all professionals working with children should be made aware of this statistic.

**Information Sharing**

9.65 There is evidence of ‘silo practice’ in this case, where agencies worked in isolation with very limited discussion and information sharing. This was particularly the case between health services, and between health and the supported housing provider. The Care Quality Commission review of
the Baby P case (CQC, 2009) outlined significant poor communication between health professionals and other agencies.

9.66 Letters were sent by Hospital 1 to the GP, who then copied them to the health visitor; however, as outlined above, on at least one occasion the information shared did not mention the presence of bruising.

**Lack of multi-agency assessment and support**

9.67 Mother was just 16 when she became pregnant, and she was living with a family member in overcrowded conditions, and without the support of her own parents. She was undoubtedly vulnerable. Despite her job as a child care worker, more questions should have been asked about her abilities to practically and emotionally care for a baby as a single parent living alone. A place was quite rightly provided for Mother in a supported housing placement where a number of pregnant teenagers live to gain experience of living independently. However, the work provided to Mother and the assessments made by that agency and by the health workers involved were insufficient.

9.68 OFSTED state in their report ‘Ages of Concern’ that assessments of pregnant teenagers must take into account their family background. There is very little information available that provides detail of Mother’s experiences as a child. All we know is that at the time of her pregnancy her relationship with her parents had broken down. We do not know why, and we do not know what Mother’s childhood experiences were. No one appears to have asked, and if they did, they did not record the details. Until we are able to engage with Mother as part of this SCR, we are unable to comment on whether knowing more information about Mother’s history would have lead to increased interventions with her in her parenting of Child B. It is clear from the IMRs that very little was known about Mother’s day-to-day life while she was living in the supported housing. In particular it was very unclear to what degree Father was involved in direct care for Child B and whether it was intended that when Mother moved into independent living that Father would be living with her. (See 9.76)

9.69 A joined up multi-agency approach to working with Mother and recognising the any limitations and challenges she would face in her role as a teenage mother was lacking in this case. A CAF would have been helpful in making sure that all involved agencies were aware of their role and responsibilities, and in ensuring that a clear plan of support was drawn up to support Mother. It is recorded in the supported accommodation notes that floating support was offered to Mother for after her move into her own property. This was initially accepted by Mother but was later refused and did not happen. The IMR says it is not clear why.

**Record Keeping**

9.70 The majority of IMRs highlighted issues with record keeping in this case. The recording of injuries was particularly poor, and this is of great concern to the IMR authors and the panel for this SCR. It is learning that has been identified in a number of other SCRs nationally and locally. The doctors with responsibility for Child B when Child B was presented at hospital and injuries were seen, did not document the bruising appropriately in the notes. They did not systematically use body maps and carefully measure the bruises, and they did not use medical forensic photographs. The health visitor did not record the bruises on her own health visiting notes.
9.71 Poor recording was also identified as an issue in the supported housing organisation, in relation to the content of key work sessions, in review of support plans, and when Mother was discharged and moved into her own property.

9.72 The EDT social worker did not record meetings with the day time team on the Monday morning before Child B died, although they made a point of going into the office to meet with them to ensure all information was passed on appropriately. They also did not record any attempt to speak to a senior manager over the weekend (albeit not the Service Delivery Manager on call, as would be expected.)

9.73 The child care provider has an identified issue with the recording of previous injuries on children, and in its confusion about how the parents who are also employees record incidents involving their own children.

**Lack of awareness, questioning and recording of the role of fathers**

9.74 To quote ‘Ages of Concern’ again; ‘previous OFSTED reports have highlighted the lack of attention to the role of fathers or male members of the family. With cases concerning babies this message is a recurrent theme. Again and again, the reviews found that fathers had been marginalised, describing them as ignored, ‘invisible’ to practitioners or ‘the ghost in the equation’. Because generally the mother is the parent who is seen much more frequently by practitioners, the reviews concluded that too often there had been insufficient focus on the father of the baby, the father’s own needs and his role in the family.’ This is clearly the case with Child B. Little more than Father’s name was ever recorded in the records. It was clear when Child B was taken to hospital that Father was very involved in the care of Child B, but still very few questions were asked.

9.75 Other than one reference to Father’s occupation on the health visiting records, he is not mentioned again. Health Visitors are well placed to routinely ask and document the status of the relationship between parents and to make enquiries about the input of fathers or male partners into the child’s care.

9.76 There also does not appear to be any discussion between the midwife and Child B’s mother, about the status of her relationship with her partner, Child B’s father, after Mother’s initial statement that ‘Father is supportive’ is recorded. Again, midwives should be more systematic in finding out and recording the role of fathers in caring for their children.

9.77 It was recorded by staff at the supported housing project that Child B’s father was visiting twice a week after the birth. Around a month later Mother stated that she was back in a relationship with the father of Child B and that he was coming to visit every day for 2 hours. This may have been an opportunity to question the extent of Father’s care of Child B and to explore how Mother felt about this.

**Optimism bias**

9.78 Research over many years has shown the dangers of optimism bias, when professionals accept unchallenged a positive view of a situation, rather than questioning the basis for this assumption. This is the case with Child B and the majority of professionals involved in its life, including the child care setting, the supported housing provider, the health visitor, the midwife, the
practice nurse and various doctors at Hospital 1. It is only after Child B is taken to hospital by ambulance with extensive injuries that child abuse is suspected.

9.79 The antidote to the loss of objectivity is good professional supervision. In ‘Working together to safeguard children 2010 it is suggested that professionals ask themselves:

- Would I react differently if these reports had come from a different source?
- What were my assumptions about this family and what, if any, is the hard evidence supporting them?

In this case there was no, or very limited supervision, as Child B had not been identified as a child in need of any additional services or of protection.

9.80 There was an acceptance of what the parents gave as explanations for the bruises, and over optimism about them being accidental rather than abusive. As stated by Blom-Cooper in his enquiry of Ashworth Hospital ‘it is the job of the supervisor to say “where is the evidence for this?” He must compel the front line workers to examine their judgements in a critical way.’ In this case there appears to have been insufficient challenge to the perception that Mother was a good and therefore protective parent. There appears to have been insufficient challenge to the perceptions of medical staff and a clear under-responsiveness, despite there being several unresolved questions and considerable uncertainties in the case.

9.81 Professionals were overly optimistic in regard to Mother’s ability to parent, which was based firstly on her job as a child care professional, and secondly on her confident practical handling of Child B and presumably the children she worked with. This optimism was in most part based on assumptions rather than after any assessment, and competent practical care does not necessarily equal a good parent.

10 KEY LEARNING

10.1 Working Together asks the following questions of reports written for Serious Case Reviews: ‘Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children? Is there good practice to highlight, as well as ways in which practice can be improved? Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources? Are there implications for current policy and practice?’ (WT 2010)

10.2 The individual management reviews list the following lessons learned, all of which are accepted by the SCR panel:

10.3 Housing Association
- All young people who have been in supportive accommodation, and are being housed by the agency, should be subject to an assessment of their support needs.
- Safeguarding training should be undertaken by all staff on an annual basis.
- All information about a potential customer should be sought to ensure that they are supported in maintaining their tenancies.

10.4 Supported Housing Organisation
- Record keeping and report writing skills must be improved.
- More background information should be sought and recorded about young people who are referred to the scheme.
• Support plans for babies and children living in the scheme should be completed and the quality of them improved.
• There should be an agreed procedure/protocol for liaising with Midwives or Health Visitors.

10.5 Child Care Provider/Employer
• There should be clear guidelines and policy regarding expectations of nurseries, and employees in caring for their own children.
• The Child Care Provider should be clear with all staff about how they record existing injuries in children.
• A Director should be the nominated person, as defined by the Ofsted Guide to registration on the Early Years Register: childcare provider on domestic or non-domestic premises (2012).
• There should be clarity regarding what actions to take, and how to record decision making where any individual who wished to work in the setting has a criminal conviction.

10.6 Shropshire Community Health NHS Trust (SCHT)
• Responses to bruising seen in young children must be improved.
• There should be liaison between the maternity services and SCHT during the antenatal period.
• Consideration should be given to seeing a child’s father.
• Information should be sought and documented regarding the mother and child’s relationship with the father and the role they play in the child’s life.
• Liaison between SCHT and Hospital 1 must be improved, to include the timeliness of notifications being received and more evidence of telephone or face to face liaison.
• A written, agreed paediatric liaison guideline is needed between Hospital 1 and SCHT.

10.7 Clinical Commissioning Group (CCG)
• Injuries should not be seen in isolation, but considered with other concerns/injuries.
• Mother’s vulnerability should have been recognised and formally assessed during pregnancy.
• Lack of multi agency involvement.
• The Midwives and Health Visitors in this case should have spoken and there should have been a written handover from the Midwife to the Health visitor.
• There was a lack of complete information sharing regarding the bruising experienced by Child B from Hospital 1 to the GP.

10.8 Children’s Social Care
• Cases where a child has life threatening injuries out of office hours should be brought to the attention of the Senior Manager on duty and direction provided.
• There is need for an improvement in how management decision making is recorded on the child’s file.
• In cases where a child has died and there has been a child protection investigation, a genogram should be put on the child’s file before it is closed.
• The handover of very significant cases from Emergency Duty Team to Day Time Services needs to be more robust.
10.9 **Hospital 1**
- Poor quality recording of injuries. External marks must be clearly drawn on appropriate body maps, with each mark accurately located in relation to bony parts, configured and measured.
- The lack of routine measurements of head circumference.
- Lack of access to clinical photography.
- Lack of consideration of previous admission/injuries.
- Lack of consideration of colleagues concerns.
- The opinion of the Named or Designated Doctor should be sought, according to Trust policies and procedures, if there is disagreement between doctors as to whether any injury to a child in their care could be abusive.

10.11 Hospital 2, the Police, the ambulance service and the out of hours GP service did not identify any lessons to be learned.

10.12 The Health Overview Report states the following learning:
- Local health agencies did not consider identification of Child B’s injuries as a safeguarding NAI requiring a referral to social care when Child B presented with bruising on several isolated occasions to different health providers until the last admission.
- Poor clinical assessment and ineffective decision making in isolation with lack of joined up health information sharing was a missed opportunity for a holistic approach and safeguarding plan to prevent further child harm.
- Communication and information sharing between health professionals locally lacked consistency with delays in Hospital 1 discharge summaries and critical child protection analysis thinking alerting to safeguarding referral.
- Record keeping across local health agencies requires further improvement in family and environment, injuries documentation, parenting capacity and child’s needs.
- The role of the significant male appears not to be addressed locally with lack of information and sufficient documentation.
- Minimal support identified for young parents by non completion of holistic pre-birth CAF assessment with other agencies involvement in Team Around the Child Meeting (TAC).

10.13 The SCR panel agreed that the main overall lessons to be learned from this review into the death of Child B are:

- All professionals working with children must consistently be aware of the research regarding bruises in infants who are not independently mobile.
- All professionals should consistently consider injuries in children alongside that child’s developmental stage.
- All agencies must consistently recognise the importance of assessing fathers and partners in their assessments and work with families.
- Recognition of the vulnerability of pregnant teenagers, with all pregnant teenagers being offered a CAF assessment of needs, and an integrated support plan. These assessments should reflect an understanding of how young parents’ experiences of being parented impacts on their capacity to nurture and care for their own children.
11 CONCLUSIONS AND RECOMMENDATIONS

11.1 Even with the benefit of hindsight, there has been no evidence identified that Father or Mother might pose a risk to children before the first bruise was found on Child B. There was no known record of domestic violence, mental health issues or drug/alcohol abuse. Child B appeared to be well cared for and thriving in Mother’s care for most of its life. When Child B was seen with bruises however, questions should have been asked and investigations undertaken.

11.2 In their short life Child B would have experienced aggression and violence which would have been both distressing and exceptionally painful. Child B was seen by a number of professionals and the parents were questioned about the bruises seen; however, none of these professionals questioned the explanations given by parents or questioned how a non-mobile child could have received them. This meant that child abuse was not considered, and Child B was not protected. Whilst it is not completely certain that any of the injuries would have lead to Child B being removed from the parents permanently, they could have led to a comprehensive assessment being undertaken which would have included an assessment of both Mother and Father, to include their relationship with each other and with Child B. Support would have been offered, and Child B may have been made subject to a multi-agency child protection plan. While this in itself may not have prevented the fatal injuries inflicted on Child B, the situation at home may have been improved by the support and oversight this would offer.

11.3 Recommendations have been made within all of the IMRs, and the SCR panel endorses them.

11.5 This SCR overview report makes the following additional recommendations:

1. That the TWSCB ensures that the learning from this SCR is shared with all relevant staff.

2. The TWSCB to ensure that the recommendations in all of the completed IMRs and the HOR are implemented by regular review of individual action plans.

3. That all relevant agencies should satisfy the TWSCB that information gathering and processes include due consideration of and systematically record the involvement of fathers and/or partners in the child’s life. This should include their appropriate and effective involvement in assessments and planning.

4. The TWSCB to ensure that all professionals working with children are aware of the research regarding bruises in infants who are not independently mobile. A simple document based on the West Midlands NHS guidance should be devised and circulated to all staff, and its messages reinforced at all training events. Staff need to be reminded that ‘babies who do not cruise, rarely bruise.’

5. The TWSCB to ensure that all pregnant 16 and 17 year olds to be offered a CAF assessment of needs, and an integrated support plan. (This will be around 40 cases per year.) These assessments should reflect an understanding of how young parents’ own experiences of being parented impact on their capacity to nurture and care for their own children.
6. The SCR panel recommends that the TWSCB requests that providers of supported housing use a suitable tool (e.g. an ‘ecomap’) to record the networks, both personal and professional, available to young people on provision of their services.