East Riding Safeguarding Children Partnership

Serious Case Review

Overview Report

Baby B

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1. Introduction

1.1 Circumstances Leading to the Review

1.1.1 The subject of this Serious Case Review is Baby B who was admitted to hospital in November 2013 due to fitting and seizures. Medical investigations established that Baby B demonstrated the symptoms of Shaken Baby Syndrome; Baby B was 10½ months old at the time.

1.1.2 Baby B was born in January 2013 as the second child of Baby B's mother MB and father FB; Baby B's older sibling was born in 2007. At the time of Baby B's birth the family lived together and were in receipt of universal services. FB worked six days each week and MB was the primary carer for the children.

1.1.3 By the time of the incident that led to this review, Baby B's parents had separated and both children were living with their mother who had commenced a relationship with SF. SF has been convicted and imprisoned for inflicting the injuries on Baby B. MB was convicted for her failure to protect Baby B, who was left with life-changing injuries as a result of this incident.

1.2 Report Format

1.2.1 Section 2 of this report explains the process that was followed in undertaken this review. It introduces the report author and lists the membership of the review team. It identifies the sources of information used to inform the review and describes the principles of the review.

1.2.2 Section 3 lists relevant family members and other members of the public who are referred to in this review. These individuals are not named but are described using their connection to Baby B.

1.2.3 Section 4 provides a factual summary of six key episodes of agency involvement with Baby B and family. It is not a comprehensive record of all contacts with the family but focuses on those episodes that are considered to be significant to the way the case developed.

1.2.4 Section 5 provides an analysis of the information using five key themes that have emerged. For each theme, learning points are identified.

1.2.5 Section 6 provides a summary of relevant, significant changes to practice that have occurred since the events considered in the review.

1.2.6 Section 7 contains the conclusions of the review.

1.2.7 Section 8 lists the learning points that are identified in the analysis.

1.2.8 Section 9 contains 10 recommendations made to East Riding Safeguarding Children Partnership. These are cross referenced with the individual learning points to which they apply.

2. The Review Process

2.1 East Riding Safeguarding Children Board (ERSCB) decided to commission this Serious Case Review in May 2019. This decision was made following completion of an investigation, in December 2018, by the Local Government and Social Care Ombudsman into complaints made by Baby B's father (FB) against East Riding Council. Within their report, the Ombudsman recommended that the Council make a referral to the East Riding Safeguarding Children Board Serious Case Review Panel (or its successor organisation when new safeguarding partner arrangements were in place.) The Council made such a referral and, following the emergence of new information, ERSCB decided that the criteria for a review had been met.

2.2 Although Working Together to Safeguard Children 2018 replaced Serious Case Reviews with Child Safeguarding Practice Reviews it was decided that, in this case, a Serious Case Review was the appropriate way forward. This is due to the timeframe being considered and the fact that, at the time of the decision, ERSCB had yet to fully transition to a Partnership.

2.3 Peter Ward was commissioned as the Independent Lead Reviewer for the review. Mr Ward has a background in social care and has worked in management and front line social work. He is qualified to degree level in social work and has a post-graduate diploma in management studies. Since 2005 he has been involved in Serious Case Reviews as an Independent Overview Report Author, Individual Management Review Author or Panel Chair. Mr Ward has undertaken training in respect of using systems approaches[1] when undertaking Serious Case Reviews and he is an accredited Lead Reviewer with Review Consulting having successfully completed the SILP[2] Lead Reviewer training.

2.4 The Learning and Improvement Manager for East Riding Safeguarding Children Partnership (ERSCP) led the process for the partnership. A 'Review Team' consisting of representatives from agencies that had involvement with the family during the time period under review was established to oversee the process. The membership of the Review Team was as follows:

- Designated Safeguarding Nurse (Chair), East Riding of Yorkshire Clinical Commissioning Group (CCG)
- Detective Inspector, Protecting Vulnerable People Unit, Humberside Police

[1] The systems approach "focuses on a deeper understanding of *why* professionals have acted in the way they have, so that any resulting changes are grounded in practice realities" (Munro, 2011). It "looks for causal explanations of error in all parts of the system not just within individuals" (Munro, 2005).

[2] SILP (Significant Incident Learning Process) is a specific approach to carrying out a review which has been developed and is owned by Review Consulting.

- Senior Probation Officer, National Probation Service, North East Division
- Safeguarding GP, East Riding of Yorkshire Clinical Commissioning Group
- Deputy Headteacher, Primary School
- Named Nurse Safeguarding Children, Humber Teaching NHS Foundation Trust
- Named Nurse for Safeguarding Children, Hull University Teaching Hospitals NHS Trust (HUTH)
- Interim Head of Service, Children & Young People Support & Safeguarding Service, East Riding of Yorkshire Council
- Service Manager, Children & Young People Support & Safeguarding Service, East Riding of Yorkshire Council
- Learning & Improvement Manager, East Riding Safeguarding Children Partnership

2.5 All relevant agencies reviewed their records and provided scoping reports and chronologies detailing their involvement with the case, including a brief analysis of their involvement. The agency chronologies were merged and used to produce an interagency chronology. This was used to inform learning and identify areas for further exploration and consideration. The timeframe for the review was agreed as from January 2013 when Baby B was born until November 2013, three days after Baby B was admitted to hospital with the life changing injuries. Chronologies and scoping reports were provided by the following agencies:

- Children's Social Care (CSC)
- Children's Independent Safeguarding and Reviewing Officer Service (CISRO)
- Domestic Violence and Abuse Partnership
- Hull University Teaching Hospitals NHS Trust (HUTH)
- Humber Teaching NHS Foundation Trust
- Humberside Police
- National Probation Service
- East Riding CCG (regarding Primary Care)
- School
- Yorkshire Ambulance Service

2.6 One principle of Serious Case Reviews and Child Safeguarding Practice Reviews is that families should be invited to contribute. The Lead Reviewer and the Learning and Improvement Manager for ERSCP met with MB, FB and PGMB as part of this review. Information they provided is included throughout the report where it informs the learning. The Lead Reviewer and the Learning and Improvement Manager for ERSCP were unable to make contact with MGMB.

2.7 Another principle is that *"practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith"*. The time period under consideration for this review pre-dated the review by six years which created some practical difficulties with regard to including practitioners in a learning event. However, the Lead

Reviewer met with SW1 and SW2 to discuss their involvement with the family during the period under review.

3. Family Structure

3.1 Relevant family members and other members of the public referred to in this review are:

Family member:	**Referred to as:**
Subject child	Baby B
Sibling of subject child	Sib B
Mother of subject child	MB
Father of subject child	FB
Paternal grandmother of subject child	PGMB
Maternal grandmother of subject child	MGMB
Maternal grandfather of subject child	MGFB
Other	
Perpetrator	SF
Child of perpetrator	CSF
Perpetrator's ex-partner	MCSF

3.1.1 The family's ethnicity is white British. There was no evidence in any of the reports submitted by agencies involved with the family that any issues of race, religion, language or culture affected events in this case.

4. Key Episodes

4.1 Introduction

4.1 Key Episode 1) Anonymous concern about neglect

4.1.1 In June 2013, the National Society for the Protection of Cruelty to Children (NSPCC) received information in an anonymous on-line reporting form expressing concern that the children may be in need or at risk due to neglect and being home alone. It did not suggest that the children were at immediate risk of significant harm and did not include details of any specific instances when the children had been neglected. This was faxed to Children's Social Care who had no previous knowledge of the family.

4.1.2 CSC made enquiries with the home school liaison officer at the school attended by Sib B who reported that the school had no worries about Sib B's presentation or behaviour although the child had had a period of absence three months previously due to being in hospital and was currently absent from school. CSC also spoke to the health visitor for Baby B and wrote that the health visitor had no worries. As a result of these responses CSC wrote to the parents to advise them of the concern and that no further action would be taken.

4.1.3 Two days after CSC received this information, MB told staff at the primary school attended by Sib B that she and FB ended their relationship after FB had got drunk and stayed out all night. MB described the incident leading to the separation as 'the final straw'. Key staff in the school were advised to keep an eye on Sib B and the home school liaison officer informed the first responder at CSC.

4.1.4 The following day MB attended hospital with a fractured foot and reported having fallen downstairs when drunk. MB was examined in the emergency department and found to have fractured her foot. The GP was informed of the injury and the planned follow up.

4.1.5 Five days after MB fractured her foot she phoned CSC to acknowledge receipt of the letter. She was happy that no action was being taken in respect of the anonymous concerns and did not mention her fractured foot.

4.2 Key Episode 2) Sib B's health and school attendance

4.2.1 Sib B was unwell in February and March 2013, was taken to hospital three times and spent two nights as an in-patient. Sib B was absent from school for approximately three weeks at the time of this illness.

4.2.2 Sib B continued to have a high rate of absenteeism and at the time CSC contacted the school regarding the anonymous concern about neglect attendance was at 74.2%. Approximately two weeks after CSC contacted the school, Sib B's class teacher spoke to the parent support advisor about Sib B having missed three out of six academic assessments due to being absent from school. As a result of this discussion, the parent support advisor phoned MB to offer support regarding attendance and missing assessments. MB was willing to accept support and an appointment was made to meet in school. At the subsequent meeting, MB said that she found Sib B's behaviour to be challenging and said that breaking her foot had put her out of routine. Support was offered relating to attendance, routines and behaviour management.

4.3 Key Episode 3) Missed health appointments for Baby B

4.3.1 Baby B received the first injections and during the first 4½ months of life Baby B was taken to the baby clinic six times to be weighed. Baby B was not taken for a six week check with the GP, a seven to nine month development review, an appointment for immunisations and a rearranged seven to nine month development review. Following the second missed appointment for the development review a letter was sent to MB advising her to contact the health visitor if a rescheduled appointment was required. MB did not respond to this.

4.4 Key Episode 4) Information about SF commencing a relationship with MB

4.4.1 From March to October 2013, the child of SF (CSF) was subject to a child protection plan due to domestic violence between SF and his then partner MCSF. The day after CSF had been de-planned, a police officer sent an email to the social worker for CSF stating that SF was believed to be in a relationship with MB. MB's home address was included as were the names and dates of birth of Baby B and Sib1. It was written in the email that this was third party information that was "Professionals only intelligence, NOT to be disclosed". SW1 recorded the content of the email in CSF's records but did not take any other action.

4.5 Key Episode 5) Anonymous concern about possible domestic violence against MB

4.5.1 On a Wednesday evening in November 2013, MB was taken to hospital by ambulance with a four day history of left sided headaches with symptoms progressively worsening. She was subsequently admitted to the acute assessment unit at the hospital where it was believed she had suffered an acute migraine attack. She was discharged in the early hours of the following morning.

4.5.2 Baby B's paternal grandmother (PGMB) was known to CSC staff in the local social work team in a professional capacity due to her employment. On Thursday morning, PGMB phoned SW2 in the local social work team and told her that MB had been admitted to hospital with headaches on the Wednesday having collapsed at home on the Monday. PGMB added that a third party had told the attending ambulance personnel that MB had been overheard asking SF why he had pushed her, that her arms were covered in bruises and that she had been bitten. PGMB expressed concern that SF might be violent and said she was worried about the children and wanted advice. She also said that she wanted to remain anonymous with regard to this contact.

4.5.3 SW2 advised PGMB to contact Early Help and Advice Team (EHAT) which was the correct course of action as all new contacts[3] regarding concerns about children were initially screened in EHAT before being passed onto appropriate services and activities. The subsequent contact from EHAT was forwarded to TM1 in the local social work team and was passed back to SW2 to take action.

4.5.4 TM1 has recorded, on the 'contact' from EHAT, that he instructed the social worker (SW2) to go to the hospital to "challenge" MB about what had happened and establish whether there is ongoing domestic violence in the relationship. TM1 has also written that if MB is going to continue in a relationship with SF, Children Services should consider removing the children and if MB was willing to end the relationship then a 'letter of expectation' should be implemented. TM1 further recorded that the contact should progress to a referral and a single assessment should be completed

[3] The word 'contact' is used to describe information provided to Children's Social Care. It becomes a 'referral' if and when a decision is taken that action is required by the Local Authority.

within 10 days. TM1 wrote on a case supervision record that if MB would not agree to leave SF then removal of the children would be explored.

4.5.5 SW2 did not undertake these actions but on the Friday afternoon SW2 met MB and Baby B at a local children's centre. During the meeting MB denied any domestic violence from SF but she said he had anger issues, got jealous, was immature and picked fights. MB told SW2 that she had ended the relationship because she did not want CSC to be involved but that she still loved him. She added that since she had ended the relationship, SF had been persistently calling at her house and she was worried about potential repercussions. PGMB joined the meeting and it was agreed that MB and the children would stay with MB's father (MGFB) and the children would stay with FB the following week. MB agreed to drop the children off with FB on Sunday or Monday.

4.5.6 Shortly after the meeting, SW2 phoned FB to tell him that the children would be staying with him. FB responded that he and MB had already talked about this and agreed.

4.5.7 PGMB told the Lead Reviewer that she contacted CSC on the Monday and Tuesday of the following week to make them aware that MB and SF had resumed their relationship. However, there are no CSC records of any contact in relation to this case after Friday until late in the afternoon of the following Tuesday when PGMB informed SW2 that Baby B had been admitted to hospital (see section 4.6).

4.6 Key Episode 6 - Admission of Baby B to hospital with life changing injuries

4.6.1 On Tuesday evening four days after SW2 had met with MB, an emergency call was made to Yorkshire Ambulance Service stating that Baby B had been found in the cot by SF having had what appeared to be a seizure. Baby B was taken to hospital by ambulance with suspected febrile convulsion. Baby B was admitted to the Paediatric Assessment Unit for further observation. History was documented of Baby B vomiting and being unwell with a temperature.

4.6.2 Early the following morning SW2 phoned TM1 to advise that Baby B had been admitted to hospital the previous evening due to having seizures. SW2 informed TM1 that MB and SF had resumed their relationship over the weekend.

4.6.3 TM1 has recorded that SW2 was asked to go and have a 'firm word' with MB and if she was not willing to end the relationship then CSC would consider child protection or legal advice. The records indicate that CSC did not take any action that day and SW2 told the Lead Reviewer she cannot remember being given the instruction that TM1 has written.

4.6.4 Also on Wednesday morning, a medical review took place as staff were concerned about a change in Baby B's clinical presentation. An urgent CT

scan was requested which was carried out at 18:00 hours. The CT scan identified multiple accumulation of blood in the brain indicating possible trauma to the brain. This was explained to the parents who were told that a referral would be made to CSC. PGMB told the paediatric consultant and nursing staff of her concerns about domestic violence from SF. Nursing staff tried to contact the CSC 'out of hours' service and left a message on an answer phone but did not receive a return call. There is no record of the 'out of hours service' receiving this message and it is reported that the service did not use an answer phone.

4.6.5 At approximately 22:30 hours on Wednesday evening, PGMB phoned TM1 from CSC. She told TM1 that Baby B had a shadow on the brain and that, although more tests were required, the consultant had said that Baby B may have been shaken. PGMB also told TM1 that SF had moved back to live with MB the previous Sunday. TM1 recorded that following this call he phoned the hospital ward, had a discussion with the staff nurse and said that SF should not come to the ward until an assessment had been undertaken by CSC. The hospital has no record of any contact from TM1 that evening.

4.6.6 The following morning TM1 asked SW2 to urgently complete a letter of expectation in relation to SF not having any contact with the children. SW2 did this and informed nursing staff on the high dependency unit that she had done so. Ward staff confirmed the outcome of the CT scan to SW2 and informed her that an MRI scan would be undertaken later that day.

4.6.7 SW2 contacted EHAT to advise that Baby B was in hospital following a seizure and that PGMB had said consultants had made a suggestion that it could be 'shaken baby'.

4.6.8 TM1 contacted DS1 from the Police and they held a strategy discussion, the outcome of which was that the S47 threshold was not met as they were awaiting further medical checks.

4.6.9 An MRI scan was completed on the Thursday afternoon which indicated that Baby B had sustained two separate shake injuries. The paediatrician spoke to the parents and contacted CSC and the Police. Two police officers were deployed to the hospital on Thursday evening to commence an investigation into Baby B's injuries. SF was arrested that same evening.

4.6.10 The following day (Friday), DS1 from the Police contacted CSC TM2 who worked in EHAT and they had a strategy discussion. The outcome of the strategy discussion was that threshold was met for S47 enquiry. It was agreed that the Police alone would progress the investigation into the injuries sustained by Baby B whilst CSC intervention would address the risks to CSF.

4.6.11 Also on the Friday, SW2 and PGMB took Sib B to the GP for what was recorded by SW2 as a 'health check'. SW2 told the Lead Reviewer that Sib B was taken to the GP at the request of the Police. She added that she did not think this was a child protection medical but was unclear what the reason

was for the health check. The GP has recorded an 'impression' that there was no underlying neglect or non accidental injury.

5. Analysis

5.1 Responses to issues around possible neglect

5.1.1 Unless there was a good reason not to do so, CSC should have sought parental consent before seeking information about the family from other agencies. Furthermore, any decision not to seek consent should have been recorded with the reasons clearly stated. In this case, there is no record of either parent being contacted or of any reason being identified as to why it was not appropriate to seek consent. Therefore, it appears that the contact with the school and health visitor was inappropriately made without the consent of either parent.

5.1.2 When the home school liaison officer and health visitor were contacted by CSC in June 2013, they said that they did not have concerns that Baby B and Sib B were experiencing neglect. However, there are reasons why CSC should have been cautious about these opinions. At the time of the contact from CSC, the health visitor had only visited Baby B at home on one occasion. This was the new birth visit that had been undertaken five months previously when Baby B was 10 days old. Since then, contact between the service and Baby B was limited to six occasions when Baby B had been taken to the clinic and weighed. The most recent occasion was six weeks before CSC phoned the health visitor. Therefore, the health visitor had limited direct knowledge of Baby B or the family's home circumstances and no direct knowledge of Sib B. Sib B was absent from school when CSC contacted the school and the home school liaison officer had no direct knowledge of Baby B or the conditions at home. CSC should have contacted the school nurse and GP to seek further information about the family before deciding whether further action was required. If more detailed information about the family was not available it would have been appropriate for Children's Social Care to have visited the family home, possibly as a joint visit with the health visitor.

5.1.3 When CSC contacted the school, the home school liaison officer said that Sib B was currently absent from school and had been unwell for three weeks in March 2013 due to being in hospital. At the time of this phone call, Sib B's attendance for the year was 74.2%. Even without the absence in March the attendance would have only been 84.7%, but the information provided to CSC did not indicate such a low attendance level.

5.1.4 The attendance level may have been due to genuine ill health but it could also have been an indicator of possible neglect. Involvement of the parent support advisor at an earlier stage and liaison between the school and the school nurse would have helped to explore the reasons for Sib B's absences. The school has a clear process which should be followed when there are concerns about a child's level of attendance. In 2013 this became operative if a child's attendance fell below 85%. It is now used when attendance falls

below 90%. This process does not include any reference to liaison with the health visitor or school nurse[4] and information provided by the school to this review suggests a lack of clarity within the school about when such liaison is appropriate and how it should be initiated.

5.1.5 MB's report of separating from FB could have been seen as a further indicator that the family might be struggling and her description of it as 'the final straw' suggested there had been previous incidents. It was good practice on the part of the home school liaison officer to contact CSC with this information. As a result of receiving this information just two days after the initial concern about possible neglect, CSC should have reviewed the decision already made that those concerns were without foundation. There is no indication that this was done.

5.1.6 Non attendance at health appointments can be an indicator of neglect. In 2013, procedures within the GP practice did not require missed appointments to be followed up. Consequently, there was no follow up to the missed six week check or the immunisations. The GP practice now uses a system whereby patients are automatically sent texts to remind them of appointments beforehand and to follow up if any appointment is missed. The practice nurse was not aware of the anonymous concern about neglect so was not in a position to consider this when Baby B was not brought to the practice for immunisations.

5.1.7 The health visitor was aware of the concern and it would have been good practice for her to have informed CSC of the missed development reviews and to have checked with CSC whether any other concerns had been reported since June. She could also have tried to undertake an opportunistic visit to see Baby B at home. She did not do this and there is no evidence to suggest that the she considered whether the missed appointments could be symptomatic of neglect. The letter sent to MB presented the seven month check as an optional check if MB wanted it, rather than a check that was for the benefit of the baby. Whilst it is correct that such health checks are 'voluntary', parents should be encouraged to take their babies. The health visitor was not aware of the incidents that had taken place since CSC had contacted her in June 2013, including the parental separation so these would not have impacted on her view of the family.

Learning Points

1. Before seeking or sharing information about members of the public practitioners must ensure that they are complying with current legislation, statutory guidance and agency polices relating to information sharing.
2. When gathering information, practitioners should analyse and critically evaluate the information they receive in order to establish how much weight can be given to it.

[4] In 2013, school nurses worked with primary age children. Health visitors now fulfil this role. See paragraphs 6.2 and 6.3 for further information.

3. Health visitors and school nurses provide a useful link between schools and health services. Schools and other services should involve them when there are possible concerns about a child's health or wellbeing.
4. Incidents should not be seen in isolation but should be considered within the history of a case so that a pattern can be discerned. Where new information comes to light decisions should be re-considered.
5. There was an over-readiness to dismiss the anonymous concerns that had been made. Although they were vague in nature, these concerns should have been afforded greater scrutiny.
6. Concerns made anonymously should be treated as seriously as those that are not anonymous.

5.2 Responses to concerns about possible Domestic Violence

5.2.1 In view of what was known about SF's relationship with MCSF it could be anticipated that domestic violence might be a feature of subsequent relationships involving him and that children living in a family group including SF may be at risk. Therefore, it was appropriate for the police to make CSC aware of the intelligence about SF's new relationship and an appropriate response would have been for CSC to have considered the information to decide whether any action was required.

5.2.2 There are a number of reasons why this was not done. The police intelligence was sent to the individual social worker who was working with CSF and their family when it should have been sent to the 'Single Point of Contact' (SPOC) box and screened by a team manager. Because it was written in the email from the police that the information was "professionals only intelligence", which was "not to be disclosed", SW1 did not know what should be done with it. Thirdly, SW1 did not consider SF to be a significant risk to children because his ex-partner had been the alleged perpetrator in respect of the incident that had led to CSF being subject to a Child Protection Plan. This view appears inconsistent with the decision that CSF should be subject to a Child Protection Plan whilst SF and MCSF were in a relationship with one another.

5.2.3 Whether or not SW1's assessment of the potential risk posed by SF was accurate, the notification from the Police should have been considered by a manager in order to decide on appropriate action.

5.2.4 Because SW1 only recorded the police intelligence about SF onto CSF's records it was not available to EHAT, TM1 or SW2 when PGMB raised concerns about domestic violence or when Baby B was admitted to hospital.

5.2.5 It is difficult to understand TM1's written decision making when PGMB raised concern that MB might have been subjected to domestic violence from SF. The information provided by PGMB was an unverified allegation of a single incident of domestic violence and was based on hearsay because PGMB was reporting what someone else had reported overhearing. CSC's only previous knowledge of MB and her children had been the anonymous concerns received in June 2013. The conclusion reached at the time was

that this was an unfounded referral and there had been no direct contact with the family.

5.2.6 The use of the word 'challenge' suggests that TM1 anticipated the need for SW2 to adopt a confrontational approach with MB but it is unclear why this would be the case. It fails to recognise the importance of reassuring MB in order to facilitate building a relationship with her. There was no apparent justification for considering the removal of the children if MB would not leave SF and CSC had no authority to make such an ultimatum.

5.2.7 The suggestion that the children might be removed if MB would not end her relationship with SF indicates a high level of concern that the children would be at risk of significant harm if this did not happen. Such a level of concern appears inconsistent with the information provided by PGMB. If TM1 had had such concerns he should have arranged a strategy discussion to consider whether Section 47 enquiries were required. This was not done and SW2 understood that she was acting under Section 17 of the Children Act.

5.2.8 In trying to understand TM1's response to the referral it is worth noting that he was the manager who had made decisions regarding SF's child. Therefore it could be expected that he would have recognised SF's name and that this might have influenced his decision making in this case. However, he has said that he was not aware that MB's partner was SF. He was also unaware of the intelligence provided by the Police in October 2013.

5.2.9 Irrespective of whether or not TM1 recognised SF's name, before deciding on a course of action, the CSC information system should have been checked to see whether MB and her children, and/or SF was known to the service. If SF's history as the parent of a child who had recently been subject to a Child Protection Plan, had been known, it would have been appropriate to hold a strategy discussion to consider whether Section 47 enquiries should be undertaken.

5.2.10 The action taken by SW2, differed significantly from the written decision recorded by TM1. SW2 told the Lead Reviewer that she did not see TM1's written decision on the contact before she visited MB. SW2 added that she understood that this contact was dealt with on a child in need basis, not a child protection one, that she was definitely not told that the children might have to be removed from MB1 and there were no grounds to do so.

5.2.11 Based on the information available to CSC, SW2's action of contacting MB and arranging to meet with her was proportionate, and the decision to hold this meeting away from the family home enabled MB to talk to SW2 without SF present.

5.2.12 Although MB told SW2 that she had not experienced any domestic violence from SF and that she had ended the relationship her comments about SF's behaviour and her feelings for him should have cast doubt on her assertion

that there had not been any domestic violence and raised concerns that the relationship might resume.

5.2.13 The plan for MB and the children to stay with MGFB over the weekend and the children to stay with FB was a means to ensure that they were all safe over the weekend and the children were not exposed to any arguments or repercussions between MB and SF the following week. The plan was a family arrangement, which seems reasonable and proportionate based on what was known at the time. A letter of expectation was not signed and no arrangement was made for CSC to check that the family had adhered to the plan or that it was being effective. Given the evident concerns about the relationship, it would have been appropriate for CSC to make checks early the following week. SW2 cannot remember what her plans were for the following week but believes that she would have contacted MB to check the effectiveness of the safety plan if events had not been overtaken by Baby B's admission to hospital. However, SW2 was not told about Baby B's admission to hospital until Tuesday evening at the earliest. Therefore two full working days passed without her making any arrangements to see MB.

5.2.14 A written record of supervision between TM1 and SW2 on the Thursday was not added to the case record until the following Monday. Therefore, it would not have been available to 'out of hours' staff if contact had been made over the weekend.

5.2.15 SW2 was aware of the need to undertake an assessment but does not recall being asked to complete this in 10 days, as TM1 recorded on the contact, and does not think this would have been the case. The timescale for completing a Single Assessment is 45 days and she considered this to be a complicated situation so the assessment would not be quick. Irrespective of the procedural timescale for completing the assessment there was a clear need to commence it promptly. By the time Baby B was admitted to hospital, there was no assessment plan in place. There had been no attempts to contact any of the family members and no information gathering had taken place from other agencies.

Learning Points

7. Clarification is needed about how police intelligence should be shared with other agencies and how those agencies should record and act upon such intelligence.
8. Decision making in respect of concerns raised with agencies should not be solely based on that concern but should also consider what is known of the subjects' histories.
9. CSC case management decisions regarding significant events should be clearly recorded on case records on the day the decision is made so the information is accessible to other staff during and outside office hours.
10. At the point of allocation CSC team managers should make clear their expectations in regard to the purpose of assessment, areas to cover and expected timescales for visiting and providing the manager with an update. This should be included within an assessment plan.

11. Safety plans should be clearly written, proportionate to the identified risk and should include arrangements for monitoring and review. They should be shared and understood with all parties involved in delivering the plan, including family members and friends.

5.3 Initial response to medical presentations

5.3.1 During MB's attendance at the emergency department and the Trauma and Orthopaedic clinic with a broken foot she gave an explanation for the injury that was consistent with the presenting injury. Subsequently, the symptoms MB described to the paramedics and hospital staff when she was taken to hospital with a history of headaches fitted with a diagnosis of migraine. She reported that she had not experienced a recent trauma and that she had no rash. There were no concerns evident and no reason to suspect domestic abuse. There is no indication that any bruising was seen to MB's arms and no reason why staff would necessarily have seen her arms. At the time of these two incidents, staff in the Emergency Department were not expected to ask patients about domestic abuse as a matter of routine; consequently MB was not asked.

5.3.2 If ambulance personnel had any concern that MB might be a victim of domestic abuse they should have written this on the YAS record and on a sheet they provide to the hospital when they arrive with a patient. Neither of these documents includes any such concern. Therefore, there is no record to support PGMB's assertion that a third party had provided such information to the paramedics. It is possible that there were omissions in the records but it seems unlikely that a statement such as the one PGMB reported to SW2 would have been entirely omitted (see paragraph 4.5.2). PGMB was not present when ambulance staff visited MB and therefore she had no direct knowledge of what had been said; she could only report what she was told.

5.3.3 YAS staff acted appropriately in conveying Baby B to hospital when it was reported that Baby B appeared to be having a seizure. Baby B received immediate medical attention in hospital and was assessed and treated appropriately in accordance with Baby B's clinical presentation. This review has not identified any shortfalls in the care received in hospital or any missed opportunities to identify, at an earlier stage, that Baby B had suffered a non-accidental injury.

5.3.4 The written record suggests that when TM1 was informed that Baby B had been admitted to hospital his response was to ask SW2 to take a confrontational approach with MB. This was an inappropriate response as there was the possibility that Baby B was seriously ill, there was no indication as to the cause of the seizures and no-one from the hospital had been in touch to suggest that Baby B might have been deliberately harmed. The information that MB and SF had resumed their relationship would rightly have been a concern to CSC and it would have been appropriate for CSC to make enquiries, including finding out who was looking after Sib B. Hospital staff had not contacted CSC but, subject to considerations regarding consent, it

would also have been appropriate for CSC to contact the hospital in order to clarify the situation with regards to Baby B.

5.4 Response to concern about possible non-accidental injury

5.4.1 The results of the CT scan provided the first concern that Baby B might have been harmed deliberately. On receiving the results of the CT scan hospital staff acted promptly in trying to contact CSC. It is not known why this was not received by the 'out of hours' service as the correct phone number is recorded in the hospital record. Nevertheless, contact did take place between hospital staff and CSC the following morning and the failure to make contact the previous evening did not have an impact on the children. This was the first communication between the hospital and CSC regarding Baby B.

5.4.2 Working Together to Safeguard Children 2013 states that "whenever there is reasonable cause to suspect that a child is suffering, or is likely to suffer, significant harm there should be a strategy discussion". Therefore the decision to hold a strategy discussion on Thursday, after the result of the CT scan was known, was correct. The strategy discussion only included TM1 and DS1 from the Police. As Baby B was in hospital, the strategy discussion should have also, at a minimum, included a paediatrician. This would have provided a better understanding of Baby B's condition and how likely it was that Baby B had suffered a non-accidental injury. This in turn would have informed the decision about whether or not the grounds were met for Section 47 enquiries.

5.4.3 It is not known why SW2 phoned EHAT when she was told that there were concerns that Baby B may have suffered a non accidental injury. SW2 was already the allocated social worker working with Baby B's family by the time Baby B was admitted to hospital and therefore it was unnecessary for EHAT to be involved.

5.4.4 Following the outcome of the MRI scan the paediatrician acted promptly to inform the parents, CSC and the police. The police attended hospital promptly and made enquiries which led to the arrest of SF that same evening. The Police informed CSC of the arrest the following day.

5.4.5 The strategy meeting should ideally have taken place on the Friday morning and should have involved, as a minimum, CSC, the Police and the paediatrician. It is not known why the strategy discussion did not take place until the afternoon and did not include the paediatrician or any other health representative. It is also not known why the only the CSC representative was a team manager from EHAT who had not been involved with the case during the previous few days and was not involved after the discussion. TM1 and SW2 should have been involved in the discussion as they had relevant knowledge about the case and were likely to be involved in subsequent assessments

5.4.6 The outcome of the strategy discussion, that a Police only enquiry would be undertaken regarding the injuries sustained by Baby B, has not been explained. There was a clear need for ongoing CSC involvement with regard to the safety and wellbeing of both Baby B and Sib B.

5.4.7 There is also no explanation as to why Sib B was taken to the GP. Where section 47 enquiries are being undertaken regarding possible physical abuse of a child it is sometimes appropriate for siblings to undergo a medical examination. When an examination is undertaken it should be carried out by a suitably trained paediatrician and not a GP. Although SW2 has said that she did not think she was taking Sib B to the GP for a paediatric safeguarding medical examinations she was not clear what the purpose of the appointment had been. The GP record suggests the GP believed they were giving a view on possible abuse or neglect. Decisions about whether or not paediatric safeguarding medical examinations are required should be made in strategy discussions but this is not well embedded in practice.

Learning Points

12. Strategy meetings must be held in a timely manner and attended by all practitioners who can provide relevant information about the situation under consideration and people of sufficient seniority to make decisions.
13. Minutes from strategy meetings should be recorded in the case record of all agencies involved in the meeting and should include a record of the arrangements for review.
14. Revised guidance is required to support decision making around the need for paediatric safeguarding medical examinations where there are concerns that a child may have been harmed. This should address issues including which children should undergo an examination, when examinations should take place, who can undertake such examinations and consent.

5.5 Professional boundaries and potential conflict of interest

5.5.1 PGMB had a close professional relationship with the social work team which covered the area Baby B lived in. Some of the staff in the team, including SW2, also had contact with PGMB outside work. She had work and personal phone numbers for some of the staff in the social work team and on at least two occasions she phoned members of the social work team out of hours to discuss aspects of the case. These calls should not have been taken by the staff members concerned and PGMB should have been advised that if she needed to contact CSC outside normal office hours then she should contact the ‘out of hours’ service.

5.5.2 Section 5.2 of this report identifies that the actions TM1 decided should be taken following PGMB’s contact expressing concern about domestic violence were out of proportion to the concerns that has been raised. It is not known why TM1 took this view but he may have given more credence to the concerns because they were being raised by a fellow professional with whom he worked.

5.5.3 Since Baby B was injured, it has been suggested by staff within the local social work team that PGMB's professional knowledge provided an added safety factor over the weekend immediately following SW2's first meeting with MB. This was not part of the safety plan and there is no evidence to suggest that it was acknowledged at the time. Even if it had been acknowledged it would have been a potential conflict of interest.

5.5.4 The close working relationship between the local social work team and PGMB created an environment in which it was easy for professional boundaries to become blurred and there are indications that this happened. It could also have compromised decision making.

5.5.5 Because of this, it is considered to have been inappropriate that the local team responded to the concerns PGMB had raised on a personal basis.

Learning Point

15. Where professionals have personal or professional relationships with a service user or someone closely involved with the service user there is the potential for professionals boundaries to become blurred. Agencies should have procedures in place to ensure that, where appropriate, the case is dealt with by someone who does not have such a relationship.

6. Significant changes to practice since the time period considered by this review

6.1 This review has considered events that took place around six years ago. The Lead Reviewer has been told about the following changes to policy and practice during the six year time period that are relevant to this review.

6.2 In 2013 health visitors and school nurses caseload managed their work. Work was allocated to an individual named practitioner and details emailed to that practitioner's email address. Health visitors worked with children up to the age of 5 years and school nurses worked with children from 5 upwards.

6.3 Following the introduction of the Healthy Child Programme 0 to 19, in 2016, Humber Teaching NHS Foundation Trust established an Integrated Specialist Public Health Nursing (ISPHN) 0-19(25) Service which delivers the Healthy Child Programme 'Pregnancy and the first five years of life' (2009) and the Healthy Child Programme 'From 5-19 years old' (2009). This integrated service is delivered by six professional teams across the East Riding and a whole team approach to the children located in the areas is adopted. Health visitors now manage caseloads of children aged 0-11years and school nurses manage caseloads of children aged 12-19 but there is an overarching approach to who is identified to support children and families. The new service introduced weekly allocation meetings where escalated work and new referrals are discussed and allocated to the most appropriate practitioner. There is also a daily duty officer in each team.

6.4 Primary, secondary and tertiary health care services in the East Riding have moved from using 'Did Not Attend' (DNA) processes to 'Was Not Brought' (WNB) processes when children miss health appointments. This change recognises that non-attendance or apparent non-engagement can be an indicator of neglect, as well as a specific instance in which a child's health needs are not being met.

6.5 HUTH is working to raise awareness of domestic abuse within the Trust and is expanding the number of situations in which patients are routinely asked whether they are victims of domestic abuse (Routine Enquiry). The Trust has an Independent Domestic Violence Advisor (IDVA) working on site two days each week. The IDVA provides an 'in reach' service to support staff and victims of domestic abuse who come into contact with the Trust. The eLearning modules have been extended to cover both Level 1 & 2 Domestic Abuse training (NHS Modules) and Routine Enquiry training.

6.6 A policy for non staff related domestic abuse has been developed in HUTH and is in the process of being ratified through the relevant safeguarding committees. There is an existing policy to support employees experiencing domestic abuse.

6.7 Routine Enquiry is embedded in Maternity Services and there is now a roll out of a programme that has been developed to raise awareness of domestic abuse and Routine Enquiry across HUTH. This three year programme is led by the Named Nurse Adult Safeguarding, the Named Midwife and the Trust IDVA. The programme will focus initially on the departments in the Trust which are first contact areas such as, Outpatient Departments and the Emergency Department. Staff in each department will be invited to complete the on line eLearning which will become part of their mandatory training. Follow up support will be provided in the department for the staff by the programme leads and the IDVA will be based in the department for a set period whilst Routine Enquiry becomes embedded in practice.

6.8 If a child has contact with HUTH and non accidental injury is suspected or there is potential for harm the Trust will follow the safeguarding partnerships safeguarding referral processes to escalate concerns and a safeguarding referral will be made. If CSC considers that the case requires a strategy discussion or meeting the expectation is that this would involve the Trust doctor involved with the case and/or a member of the Safeguarding Team and staff involved in the child's care. To support the attendance of the doctor at the meetings, every effort would be made to hold any meetings on the Trust site.

6.9 In June 2014 EHAT became the Early Help & Safeguarding Hub (EHaSH). This change was brought about as a result of the co-location of the Police Protecting Vulnerable People (PVP) Team. EHaSH is a single point of contact for professionals or members of the public who have concerns about a child or young person. It provides the first response to all initial enquiries / expressions of concern and determines the most appropriate response to identified needs including:

- Fast tracking child protection concerns or other complex family situations that might require an immediate safeguarding response.

- Early, co-ordinated use of the Early Help Assessment.
- Referring on to Children's Centres, Youth & Family Support and signposting on to other services.

7. Conclusions

7.1 The information provided by the Police about MB and SF commencing a relationship did not receive suitable consideration or action by CSC. Furthermore, the information was only recorded within the case records of CSF. Consequently, when PGMB raised concern about possible domestic violence in the relationship between MB and SF, this information was not available to the team manager or social worker. Had this information been available, it might have resulted in a strategy discussion being held to consider whether Section 47 enquiries should be undertaken. Based on the information that was available to the social worker, the initial response to the concerns raised by PGMB was proportionate and timely. However, an assessment plan was not made and no follow up action was taken after the weekend. Notwithstanding these shortfalls, and even if CSC had realised who SF was, it could not have been anticipated that Baby B was likely to suffer the injuries that were inflicted just a few days later. Furthermore, even if CSC had become aware on the following Monday or Tuesday that MB had resumed her relationship there would not have been any grounds for removing the children from her care at that time.

7.2 The medical response after Baby B was taken to hospital was appropriate. After it was suspected that Baby B might have sustained non-accidental injuries there were shortfalls in relation to strategy discussions, subsequent Section 47 enquiries and medical intervention with Sibling B. Ultimately this did not impact upon the physical wellbeing of Baby B or Sibling B.

7.3 Section 5.1 of this report identifies several learning points concerning the response to issues around possible neglect in June 2013. Because the concern about neglect was not fully explored and there was no face to face engagement with the family it is not known whether it had any foundation. A more robust response in June 2013 might have led to CSC or Early Help involvement with the family but it is not possible to know how this would have impacted on subsequent events.

7.4 It is believed that the close professional relationship between PGMB and the social work team that worked with the family led to a blurring of professional boundaries and impacted on some of the decision and actions taken by members of that team.

8. Learning Points

1. Before seeking or sharing information about members of the public practitioners must ensure that they are complying with current legislation, statutory guidance and agency polices relating to information sharing.
2. When gathering information, practitioners should analyse and critically evaluate the information they receive in order to establish how much weight can be given to it.

3. Health visitors and school nurses provide a useful link between schools and health services. Schools and other services should involve them when there are possible concerns about a child's health or wellbeing.
4. Incidents should not be seen in isolation but should be considered within the history of a case so that a pattern can be discerned. Where new information comes to light decisions should be re-considered.
5. There was an over-readiness to dismiss the anonymous concerns that had been made. Although they were vague in nature, these concerns should have been afforded greater scrutiny.
6. Concerns made anonymously should be treated as seriously as those that are not anonymous.
7. Clarification is needed about how police intelligence should be shared with other agencies and how those agencies should record and act upon such intelligence.
8. Decision making in respect of concerns raised with agencies should not be solely based on that concern but should also consider what is known of the subjects' histories.
9. CSC case management decisions regarding significant events should be clearly recorded on case records on the day the decision is made so the information is accessible to other staff during and outside office hours.
10. At the point of allocation CSC team managers should make clear their expectations in regard to the purpose of assessment, areas to cover and expected timescales for visiting and providing the manager with an update. This should be included within an assessment plan.
11. Safety plans should be clearly written, proportionate to the identified risk and should include arrangements for monitoring and review. They should be shared and understood with all parties involved in delivering the plan, including family members and friends.
12. Strategy meetings must be held in a timely manner and attended by all practitioners who can provide relevant information about the situation under consideration and people of sufficient seniority to make decisions.
13. Minutes from strategy meetings should be recorded in the case record of all agencies involved in the meeting and should include a record of the arrangements for review.
14. Revised guidance is required to support decision making around the need for paediatric safeguarding medical examinations where there are concerns that a child may have been harmed. This should address issues including which children should undergo an examination, when examinations should take place, who can undertake such examinations and consent.
15. Where professionals have personal or professional relationships with a service user or someone closely involved with the service user there is the potential for professionals boundaries to become blurred. Agencies should have procedures in place to ensure that, where appropriate, the case is dealt with by someone who does not have such a relationship.

9. Recommendations

9.1 It is recommended that East Riding Safeguarding Children Partnership ensure:

1. That staff within all partner agencies are familiar with relevant information sharing guidelines and comply with these. (Learning Point 1)
2. That when gathering information and undertaking assessments, practitioners consider case histories and analyse and critically evaluate the information provided. (LP2, 4, 5, 6 & 8)
3. That communication pathways between schools and the Integrated Specialist Public Health Nursing 0-19(25) Service are well established. (LP3)
4. That partner agencies have a clear understanding of how 'professional intelligence' should be recorded and used. (LP7)
5. That CSC reviews its case recording policy with regard to the timeliness of management decisions being recorded. (LP9)
6. That written assessment plans and safety plans within CSC are clear, robust, timely and effectively overseen, and are shared with all involved parties. (LP10 & 11)
7. That strategy discussions and meetings are being held in accordance with the guidance within Working Together to Safeguard Children 2018, including timeliness and attendance. (LP12)
8. That the minutes of strategy discussions are included within the case record of all agencies involved in the meeting and include the arrangements for review. (LP13)
9. That clear, up to date guidance is put in place concerning paediatric safeguarding medical examinations. (LP14)
10. That all partner agencies have procedures in place to identify and address possible conflicts of interest. (LP15)

Appendix 1 – Initials

CAF – Common Assessment Framework
CISRO - Children's Independent Safeguarding and Reviewing Officer Service
CCG – Clinical Commissioning Group
CSC – Children's Social Care
DNA – Did Not Attend
DS – Detective Sergeant
EHASH – Early Help and Safeguarding Hub
EHAT – Early Help and Advice Team
ERSCB – East Riding Safeguarding Children Board
ERSCP - East Riding Safeguarding Children Partnership
HUTH – Hull University Teaching Hospitals NHS Trust
IDVA – Independent Domestic Violence Advocate
ISPHN – Integrated Specialist Public Health Nursing
LADO – Local Authority Designated Officer
NSPCC – National Society for the Prevention of Cruelty to Children
PVP – Protecting Vulnerable People
SW – Social Worker
TAF – Team Around the Family
TM – Team Manager
WNB – Was Not Brought
YAS – Yorkshire Ambulance Service