



Wolverhampton LSCB

Serious Case Review Overview Report

Services provided for Child F and his family

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1. INTRODUCTION

- 1.1. Between December 2015 and November 2016, Wolverhampton Safeguarding Children Board (WSCB) conducted a Serious Case Review (SCR) in relation to the services provided for an infant, referred to in this report as Child F. At the age of two weeks, Child F suffered a serious head injury, together with multiple fractures. Child F died as a result of the head injury some weeks later.
- 1.2. The SCR was carried out under the guidance *Working Together to Safeguard Children 2015*. Its purpose is to undertake a '*rigorous, objective analysis...in order to improve services and reduce the risk of future harm to children*'. LSCBs are required to '*translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children*'.¹ This document sets out the SCR findings which, in keeping with the statutory guidance, are published in full.

Reasons for conducting the Serious Case Review

- 1.3. In October 2015 Child F was admitted to hospital in Wolverhampton suffering from cardiac arrest and a suspicious head injury with associated injuries to his eyes. After his condition was stabilised Child F was transferred to the intensive care unit of Birmingham Children's Hospital where further investigations identified fractures to his ribs and to both legs. All of the injuries were strongly indicative of physical abuse.
- 1.4. Brief review of agency records by WSCB confirmed that Child F's mother had been the subject of a child protection plan as a teenager and that the local authority had carried out a pre-birth assessment during her pregnancy with Child F. In the week before his hospital admission, Child F's parents had presented him twice to the Emergency Department of the hospital in Wolverhampton. The local authority established that the young man who may have inflicted the injuries had himself been in local authority care.²
- 1.5. The Serious Case Review Committee of WSCB considered Child F's history at its meeting on 1 December 2015 and recommended that the circumstances met the criteria for undertaking a SCR on the grounds that the child had suffered serious harm and there was cause for concern about the way in which agencies had worked together to safeguard the

¹ *Working Together to Safeguard Children* (2015), 4.1 and 4.6

² Until the criminal trial it had not been confirmed that this man was the child's father; however he was treated as such during the review as he had had contact with services at a number of points.

child. Alan Coe, the independent chair of WSCB, confirmed the decision to hold a SCR on 14 December 2015.³

The focus and scope of the Serious Case Review

- 1.6. In its initial discussions the review team carrying out the SCR agreed the terms of reference for the SCR and specific aspects of service provision which it wished the review to investigate. These are set out in Appendix 1.
- 1.7. As scrutiny of records and interviews with staff progressed, the review focused its work on the following topics which form the basis of this report:
 - Arrangements for the identification and referral of need and risk during the mother's pregnancy (February - October 2015)
 - The quality of the social care pre-birth assessment and the professional and organisational factors that influenced this
 - The approach of professionals to the identification of fathers, male carers and the household composition
 - The role of the health visiting service including arrangements for antenatal visits and the primary health visit (new birth visit)
 - The identification and management of possible safeguarding concerns in the Emergency Department at the district general hospital
 - Arrangements made for contact between Child F and members of his family at Birmingham Children's Hospital after he had been injured
- 1.8. The review team scrutinised records of the medical and nursing care of Child F when he presented with serious injuries at Wolverhampton, the police investigation into the cause of the injuries or the medical and nursing care provided to him at Birmingham Children's Hospital. It decided that there was no need to evaluate the services provided during these contacts any further.
- 1.9. As the review progressed it became apparent that a number of the agencies involved were undergoing organisational changes during the period when they had contact with Child F and his mother. The SCR has therefore sought to understand whether these had an impact on the provision that was made and how in future the LSCB might work to understand and monitor the effects of such changes.

³ There was a gap of some weeks between the injuries that caused Child F's death and the legal decision to withdraw medical care. Post mortem findings were not available at the time when the LSCB considered the case. The safeguarding children board has subsequently noted that the Serious Case Review is also required under the regulation which requires a review when a child has died as a result of abuse or neglect.

Agencies involved

1.10. The SCR considered the work of the following agencies and contracted professionals:

- City of Wolverhampton Council (Children and Young People Services, including the Youth Offending Team)
- West Midlands Police
- Royal Wolverhampton NHS Trust (maternity, Emergency Department at the district general hospital, health visiting service)
- Birmingham Children's Hospital NHS Foundation Trust (intensive paediatric care for Child F after he was injured)
- National Probation Service (West Midlands)

GP and primary care services had very limited involvement during the period under review

How the review was undertaken

1.11. Details of the principles underlying the approach to review and the steps taken to carry it out are set out in Appendices 2 and 3.

1.12. Early in the review members of the review team met the mother and maternal grandmother of Child F to inform them about the decision to conduct a review and to invite them to contribute after the conclusion of the criminal trial. Information was confirmed in writing and the mother consented to the review of her own and Child F's medical records for the SCR.

1.13. After the trial the lead reviewer and the LSCB Business Manager held a brief meeting with the mother and other family members. They had moved away from Wolverhampton and had not initially responded to contacts from the review team. On this occasion it was not possible to explore the views of family members in full. The mother felt that generally professionals had tried to help and being doing their jobs; she repeated views previously expressed that she had concerns about the actions of staff in the Emergency Department. These contacts have been explored in detail in Section 3.1 and 3.6 of this the report. The safeguarding children board has made further but unsuccessful attempts to contact family members.

1.14. The father of Child F was informed about the review in writing with the assistance of the National Offender Management Service as he was remanded in custody. He was also contacted via the National Probation Service after the conclusion of the criminal trial but did not respond.

Criminal investigation

- 1.15. Child F's father was convicted of his murder. His mother was found not guilty of any offences in connection with the injuries or death.

2. BACKGROUND AND KEY EVENTS

- 2.1. This section contains a summary of key events. Limited detail is provided in order to protect the privacy of family members. Some events are described further as part of the evaluation of services in Section 3 of the document.

Family background and relationships

- 2.2. Child F's mother is in her late teens. Child F was her first child. During her adolescence, the mother was made the subject of a child protection plan because there was evidence that her own mother was in regular contact with a man who had been convicted of sexual offences against children. Child F's mother and grandmother moved to another local authority in order to avoid engaging with social workers in Wolverhampton.
- 2.3. After a brief period Child F's mother ceased to be the subject of the child protection plan. She told a social worker that the family moved back to Wolverhampton during her pregnancy. During the local authority pre-birth assessment in April 2015, the grandmother stated that the sex offender had died. This information was true, but it was not checked; nor was it shared with other agencies.
- 2.4. The mother and her family provided misleading information about the identity of the father of Child F on a number of occasions. Early in the mother's pregnancy professionals were concerned about a young male who attended appointments with the mother and was considered to be immature and disruptive. During visits family members described this person as a local youth who suffered from behavioural and learning problems. Later they specifically denied that he was the father of Child F. On another occasion a young man presented himself as the mother's cousin and denied being the father of the baby. He may have been the same person. The man now acknowledged as the father gave the probation service the family home as his address; but it remains unclear whether he was a full time member of the household before or during the life of Child F.
- 2.5. The difficulty that professionals had in identifying the father and the steps that they took to overcome them are discussed in Section 3.4.

Provision made during the antenatal period and the initial recognition of concerns

- 2.6. The mother's pregnancy was confirmed at an early point but the antenatal booking appointment did not take place until fifteen weeks because it proved hard to make an appointment with the mother. At this appointment the community midwife identified a series of social and health concerns as a result of which she referred the mother for

consultant-led antenatal care (i.e. antenatal appointments would be held mainly at the hospital and directly overseen by a consultant).

- 2.7. The midwife also asked the local authority to confirm if the mother was known to social care because she had been very reticent to answer questions about her background or to identify the father of the baby. Linking the information that it identified in its own records with the midwife's concerns, the local authority treated this as a referral and initiated a pre-birth assessment.
- 2.8. Further scans and antenatal appointments were offered both at the hospital and at the GP surgery. Between 15 and 30 weeks the mother missed several appointments, though on some occasions appointments were made very close to one another in different locations, so she may not have been clear whether she was expected to attend all of them. From 35 weeks the mother kept all her appointments and no further health concerns were identified.
- 2.9. During the pregnancy, midwives made referrals to the local children's centre and to the Family Nurse Partnership, a project with health workers offering parents a high level of support until their child reaches the age of two. The mother declined both offers of help.
- 2.10. Although the antenatal service remained involved and worked with the mother throughout her pregnancy, it is difficult to draw together a picture of the way in which services planned to meet her needs because after the initial contacts there were a large number of different midwives involved. This is discussed further in Section 3.2.

The local authority social work assessment of Child F's mother

- 2.11. A community midwife initially contacted the local authority on 21 April 2015, after the booking appointment, identifying a series of concerns about how the mother had presented. The referral was reviewed by social care and referred to a locality team for a pre-birth child and family assessment. This decision was taken because of the history of involvement of the family with social care (summarised above) and the concern that the mother and her family might still be in contact with a sex offender.
- 2.12. Noting the possible complexity of the case, the allocated social worker liaised with the antenatal service to say that she had provisionally booked a child in need meeting for 18 May 2015 in order to agree a plan of support during the pregnancy. Following a social work assessment visit on 12 May 2015 the social worker decided that the local authority would not need to be involved and that no meeting was required. It was left to other agencies to continue to support the mother and to re-refer

the family to the local authority if they had concerns. No steps were taken to coordinate the work of agencies that remained involved.

- 2.13. Although the social work visit was made in May 2015 it was not written up and authorised by a manager until mid August. The social worker had conversations later in the pregnancy with a midwife and with the Youth Offending Team (YOT) worker. These confirmed that the mother had not accepted the suggestion of a referral to the Family Nurse Partnership. There was no local authority social care involvement during the last two months of the pregnancy and during this period the main contact between the local authority and health services was between the YOT workers and the antenatal service.
- 2.14. Sections 3.3 of the report considers the assessment undertaken by the local authority and the reasons for the decisions and actions of the staff involved.

National Probation Service involvement with the father

- 2.15. Between May and October 2015 the National Probation Service was responsible for supervising the father of Child F. This followed his convictions for burglary and robbery committed in 2013. The work of the service was focused on his offending. Three early appointments were carried out by the allocated Offender Manager, who was qualified to supervise low and medium risk offenders.⁴ Later she had a period of sick leave as a result of which the father saw a series of duty officers. This disrupted the service provided.
- 2.16. When his contact with the probation service began the father was not living in a household with children or believed to have any significant contact with children. As a result no checks were made with social care. At an early appointment the father disclosed that he had been forced to leave his accommodation because of an allegation of sexual assault against a young child. His offender manager confirmed with the police that there had been insufficient evidence to pursue this allegation. No enquiries were made with the local authority to find out more about the allegation or the father's family circumstances.
- 2.17. In May 2015 he also disclosed that his girlfriend was pregnant. He also later mentioned plans to go on holiday with members of his extended family who had children. No steps were taken to evaluate whether there might be safeguarding concerns for the unborn baby or other children that he had contact with. Immediately after the birth of Child F the father

⁴ <https://nationalcareersservice.direct.gov.uk/job-profiles/probation-services-officer>

told his offender manager that the mother and child might be coming to live with him.

- 2.18. Probation service contact was exclusively with the father. This was part of a pattern whereby agencies worked exclusively with one partner without confirming the identity of the other partner or being able to explore the extent to which they would together be able to meet the needs of a baby. This is explored further in Section 3.4.

Youth Offending Team involvement with the mother

- 2.19. In July 2015 the Youth Offending Team (YOT) became responsible for supervising the mother on a Referral Order following her conviction for shoplifting. This is a standard youth justice disposal and is designed to lead to a tailored intervention package. There was a delay in setting up this programme as the mother missed appointments.
- 2.20. From early July the the school nurse attached to the YOT had contact with antenatal services and the mother's GP. As the pregnancy progressed the focus of the work shifted away from the mother's offending towards trying to help her prepare for the birth of her child and to make arrangements for support services to be put in place. Supervision and engagement in reparation and work focused on offending were limited due to the late stage of mother's pregnancy. This was accepted by the Referral Order Panel that was overseeing the work.
- 2.21. In contact between the allocated social worker and the YOT worker in mid July 2015 it was confirmed that social care would not be involved with the family. It was noted that there were 'no concerns' about mother's possible exposure to the convicted sex offender. The social worker made it clear at this point that the mother had declined to take up the referral to the Family Nurse Partnership.
- 2.22. The YOT worker made a home visit late in the pregnancy during which the mother and maternal grandmother were seen. Although they gave her a lot of help, the YOT workers were unable, despite making several enquiries, to establish the identity of the father. Shortly before the birth the YOT explained to the mother that it had been agreed to schedule the next visit after the birth of the baby. This was in line with the relevant youth justice national standards.

Birth and post-natal follow up

- 2.23. Child F's birth was uneventful. The midwife who delivered him remembers there being anxiety about the progress of the delivery and tension between family members during the birth. She told the SCR that this was within levels not uncommon during a birth. When Child F was

checked there was concern that he had jaundice which resulted in him being kept in hospital for treatment.

- 2.24. Child F was discharged home at 4 days. Follow up at home was made by community midwives and support workers on four occasions over the next six days. No concerns were identified during these visits and by the final visit Child F had gained weight above his birth weight, in line with normal expectations.

First presentation at Emergency Department

- 2.25. At eight days Child F was taken by his mother and father to the Emergency Department (ED), with a rash giving the history that he had had a temperature. He was seen by an experienced paediatric ED consultant. His temperature was normal and he showed no signs of being unwell. As his mother said that he had had a temperature during the birth, the consultant decided to admit Child F to the paediatric assessment unit for observation overnight in order to eliminate any risk that he might be suffering from blood poisoning.
- 2.26. After waiting for some time the parents left the ED, discharging the baby before he could be admitted. Due to a misunderstanding over which consultant needed to be informed about the discharge and how that should happen, there was a delay in the ED consultant being told. Arrangements were made for a visit by a midwife at home the following day. This took place (it is one of the visits described in paragraph 2.24) and no concerns were identified.

Primary (new birth) visit by the health visitor

- 2.27. The primary health or new birth visit was made by the allocated health visitor at the age of ten days. There had been no pre-birth health visiting contact. This would have been indicated for a woman in these circumstances but the health visiting service records show that no final confirmation of a viable pregnancy was received from the antenatal service.
- 2.28. The new birth visit coincided with the last of the visits made by a midwifery support worker to weigh Child F. This meant that the visit lasted longer than normal and that the health visitor was able to see Child F without any clothes on, though she would not have been expected to carry out a physical examination. She observed nothing out of the ordinary and she was aware of Child F's weight gain.
- 2.29. During the visit the health visitor saw the mother, the maternal grandmother of baby and a young male who introduced himself as the mother's cousin and participated in the care of the baby. The mother was asked about the child's father and was told that the mother had

minimal contact with him and that she wasn't happy to disclose his details.

- 2.30. The health visitor observed an alert, well baby and positive interaction between the mother and infant. The baby fed well. The visit covered all of the expected areas of infant and maternal health with the exception of the hearing test. This was because the health visitor felt the visit had gone on too long and the infant was too distracted for the test to be reliable.
- 2.31. It was noted that the mother had declined the offer of involvement in the Family Nurse Partnership during the pregnancy. However at the visit she signed a form for information sharing and referral to the children's centre and agreed to participate in the normal health visiting and baby clinic programme. Two further visits were scheduled to take place in November 2015 in line with the normal local arrangements.

Second presentation at Emergency Department

- 2.32. At 12 days (two days after the primary home visit) Child F was taken to the ED by his mother and a man whom the hospital took to be the father. Child F was physically examined first by a very experienced ED staff nurse, then by a junior doctor. The parents reported three problems: 1) a history of pain or swelling in Child F's leg; 2) they said that he sometimes 'looks like he has stopped breathing for few minutes and then recovers' and also 3) that he had not opened his bowels for two days. The father referred to problems that had been identified with the child's leg during pregnancy and after the birth and also referred to the family's previous concerns about the difficulty that a nurse had had taking blood from Child F's foot.
- 2.33. The junior doctor undressed Child F and gave him a very detailed physical examination, finding no signs of pain or injury to the leg and nothing else of concern. He documented the examination systematically and discussed his findings with the consultant who was in charge of the ED that evening. All three staff members told the SCR that they were aware of the possibility of safeguarding concerns given the reported presenting complaint and the age of the baby. All were reassured by the results of the examinations and the interaction observed or described between the parents and the baby. The consultant offered to see Child F himself but he and the junior doctor agreed that this was not necessary. Feeling that these were most likely anxious and inexperienced parents who might benefit from some further reassurance, an appointment at the ED paediatric clinic the following morning was made.
- 2.34. Child F was not brought to this clinic. Like her colleagues the ED consultant who was running the clinic was initially concerned by the age of the baby and the report of the initial presentation. She too was

reassured by the very thorough account of the examination, though she assumed wrongly that the consultant had also examined the baby as well. Child F was discharged from the clinic and emails were sent to the midwives and health visitors. No discharge or non-attendance letter was prepared for the family GP.

Final presentation of Child F to the Emergency Department

- 2.35. There was no further professional contact with Child F and his family between this ED attendance and the point two days later when he was brought by ambulance to the ED gravely ill. Subsequently the following injuries were identified: a very serious head injury together with associated severe damage to the backs of the eyes; several fractures to the legs and several fractures to the ribs. All were extremely suspicious and indicative of an abusive assault by an adult
- 2.36. The head injury would have caused Child F's immediate collapse and is therefore likely to have occurred in the hours before the parents called the ambulance. The other injuries are likely to date from the same episode. Expert medical opinion is that one of the fractures to Child F's leg may have been caused earlier, though that is by no means certain.
- 2.37. West Midlands Police began a criminal investigation immediately the suspicious injuries were identified.
- 2.38. Child F subsequently required intensive care as a result of the head injury. He died when this was withdrawn with the agreement of the High Court four weeks after being injured.

3. SERIOUS CASE REVIEW FINDINGS

3.1. Could injuries to Child F have been identified at an earlier point?

Introduction

- 3.1.1. Child F suffered catastrophic head injuries shortly before he was brought to hospital. Expert medical opinion is that he suffered other non-fatal fractures to his legs and ribs during the same assault. He had one fracture in his leg which may predate these injuries, indicating that there may have been an earlier assault.
- 3.1.2. Child F's father has continued to deny responsibility for causing his death. It is therefore not clear whether the parents were aware of the danger that could arise from shaking a small baby, for whatever reason. The SCR will therefore recommend that action is taken by the safeguarding board and its member agencies to ensure that information about the danger of shaking a baby are made available to all prospective and new parents in Wolverhampton.

Evidence identified by the SCR

- 3.1.3. The SCR has considered whether the possible earlier injury might have been detected during contacts between professionals and Child F. In her contribution to the SCR, Child F's mother expressed concern that his injuries had not been identified when he was taken to hospital.
- 3.1.4. As it was the last contact that he had with professionals before the injuries that caused his death, attention has focused on Child F's attendance two days before being fatally injured when his parents brought him to the Emergency Department (ED) giving the history of concerns about his legs.
- 3.1.5. However it is important to note that there had been a number of other contacts prior to this during which professionals closely observed Child F. The day before he attended ED, Child F had been undressed and weighed by a health support worker in the presence of his health visitor who was undertaking the primary health (new birth) visit. No signs of injury or concerns were noted.
- 3.1.6. Three days prior to that Child F had been brought to the ED with a rash and reported temperature. On that occasion he had been undressed and examined by a paediatric ED consultant and found to be well. The next day when seen by a midwife at home he was also well.
- 3.1.7. Review of the hospital records and interviews with the staff involved during Child F's second ED attendance show that the parents' accounts varied, referring at different points to a sore left leg, a swollen leg and the baby crying when the leg was touched. At the same time the mother

described how since birth he had had 'problems with both legs'; the father reported that Child F had been identified as having short legs in scans during the pregnancy, though he said that 'nothing had been done about it'; he also referred to the difficulty that midwife had had taking a blood sample shortly after the birth, causing bruising to the baby's foot.

- 3.1.8. In the ED Child F was examined by an experienced ED nurse and then by a junior doctor. He in turn discussed the findings with the ED consultant. Neither examination found evidence of swelling, soreness or bruising. Records of both examinations refer to a contented, apparently well baby who was feeding normally and being apparently well cared for. On that visit, no x-ray was taken because the clinical examination did not point to any injury or pain. No check was made of the mother's obstetric records to see if there had been concerns during the pregnancy or on the post-natal ward or to verify the father's account.
- 3.1.9. The conclusion was that Child F's parents were young, inexperienced and anxious and an appointment was made for them to attend the paediatric follow up clinic the next morning where they would be able to have a longer conversation with a Paediatric ED Consultant.
- 3.1.10. Given the history provided by the parents (and particularly taking account of the inconsistencies in their descriptions) and with the benefit of the information and expert assessment that is now available, the review recognises that Child F's leg may have been injured before this attendance. If that was the case it is possible either that one or both parents knew of an incident that might have caused the injury and wanted the child to be checked over or that one parent was concerned about the leg being sore without knowing why that was, but wanted reassurance or an explanation. The leg may also have been injured prior to the contacts with health visitors mentioned in Sections 3.1.3 and 3.1.4 above though on neither occasion did either parent mention a sore leg.
- 3.1.11. To improve future service provision it is useful to consider whether any more could have been done during the second ED attendance and whether it might have led to the detection of an earlier injury.

Commentary

- 3.1.12. It is very difficult to identify a fractured limb in a small baby. Immediately after such an injury a baby may be very distressed, followed by a period of a few hours when the affected limb may be sore when touched. After this there may be no symptoms.
- 3.1.13. Fractures of small children are often very difficult to recognise on x-ray and open to misinterpretation. Evidence of the existence of many fractures in small children can only be detected by the accumulation of

new material growing around the site of the injury as the bone heals. These signs of healing usually appear after 7 – 14 days.

- 3.1.14. The best clinical practice when evaluating possible injuries to very small children is therefore to x-ray the site of the pain or reported injury when it is presented and then to arrange for a second x-ray after a period of several days. In relation to Child F it is very unlikely that any injury would have been identified if he had been x-rayed during this ED attendance. Given the need to delay a second examination until possible signs of healing would have begun to be visible Child F would not have been x-rayed again before he was fatally injured.
- 3.1.15. During the second ED visit staff should have looked at the previous ED record. It would also have been useful for the ED to have accessed Child F's birth records and his mother's obstetric records to establish if there had been previous concerns about his legs. Interviews with staff suggest that although the department is often extremely busy, on this occasion there would have been time to do this. It was not considered because it was not at the time part of the established practice in the department.
- 3.1.16. The decision to offer a follow up appointment the next day showed that the doctors who saw Child F recognised that his parents were young and anxious and may have needed reassurance and guidance. At the time staff seeing a child out of hours in the ED sometimes referred children to a clinic the next day. The hospital has discontinued this practice, recognising the potential harm that might arise in some instances from doctors deferring a judgement about the safeguarding of the child.

Summary

- 3.1.17. Expert opinion is that the majority of Child F's injuries occurred as part of the assault that caused his death. There is one fracture that may predate this event, though that cannot be stated with certainty. Signs of this fracture are very unlikely to have been identifiable before the assault that caused his death because the healing would not have been sufficiently advanced. It is therefore not possible to say that different management of Child F when he attended ED on this occasion would have led to the identification of his injuries or prevention of further injuries.
- 3.1.18. However the conclusion that there were no safeguarding concerns was reached too quickly on the second ED visit. Though the evidence is that it was carried out competently, too much reliance was placed on the medical examination of Child F – which proved normal - and insufficient account was taken of the concerning and inconsistent history given by his parents that an immobile baby may have shown signs of having an injured leg.

3.1.19. These events highlight the complexity and the lack of certainty that health professionals have to deal with when making judgements about risk to small children in the ED. There are wider lessons for the identification, clinical management and the organisation of possible safeguarding concerns in emergency departments. These are addressed further in Section 3.6 which draws on useful wider research on this issue and makes recommendations about the oversight of safeguarding practice in the hospital.

3.2. Arrangements for the identification, referral and assessment of need and risk during pregnancy

Introduction

3.2.1. This section of the report considers the action taken by agencies during the mother's pregnancy to identify the support needs of parents and to assess possible risk to the baby after the birth. The pre-birth assessment undertaken by the local authority is dealt with separately in Section 3.3.

Evidence identified by the SCR

3.2.2. The community midwife identified concerns about Child F's mother at the antenatal booking appointment, which was at 15 weeks. These were: her age; reported previous pregnancies (bearing in mind her young age) and a reported history of unexplained 'blackouts' she said had never been reported to a doctor or investigated. The midwife referred the mother for 'consultant led' care (i.e. a combination of hospital appointments with obstetricians and midwives, as well as community midwife appointments at the GP surgery). The referral was to a consultant recognised as having interest and experience in caring for women with identified mental health difficulties or social risk factors.

3.2.3. At the booking appointment the mother was asked routine screening questions about mental health and domestic abuse and the records indicate that she did not provide any significant information. There is no evidence in the records that screening over mental health or domestic abuse was repeated later in the pregnancy as is often considered to be good practice.

3.2.4. Following this appointment the midwife made contact with social care to find out whether the mother was known to the local authority and with a request for information. Concerns identified by the midwife who undertook the booking appointment were followed up by the allocated midwife. Further discussions with social care stressed that the midwives had found the mother very difficult to engage and unwilling to consider the sort of services that might assist her. Together with the information

that it already held in its records, this led the local authority to decide that it needed to undertake a pre-birth assessment (see section 3.3).

- 3.2.5. The social care pre-birth assessment visit was undertaken on 12 May 2015, after which the social worker contacted the community midwife to say that the local authority would not remain involved with the family and that no child in need meeting would be held. The social care assessment is discussed further in Section 3.3.
- 3.2.6. In the absence of a child in need meeting or social work involvement there was no coordination of the activity of agencies. Antenatal appointments were offered both at the hospital and at the GP surgery. Between 15 and 35 weeks the mother missed a number of these appointments, but usually responding to reminders or rescheduled appointments. On some occasions appointments were offered soon after one another at the hospital and the GP surgery. This may have made it difficult for the mother to understand why she needed to attend them all.
- 3.2.7. The health visiting service did not make an antenatal visit to the mother, which might have been helpful. Health visiting records show some sharing of information from the antenatal service (which is part of the same health trust); however the health visiting records do not contain confirmation that the pregnancy was planned to continue to term, usually sent at about 20 weeks. Interviews with staff suggest that the mother would not in any event have been allocated to a pre-birth visit as these were not being offered at the time.
- 3.2.8. The Youth Offending Team continued to work with the mother and had some contacts with the community midwives.
- 3.2.9. Overall the family remained uncooperative and difficult to engage, until the final few weeks of the pregnancy. This was a young pregnant woman for whom there should have been some form of coordinated working. This could have been provided by an Early Help Assessment and the allocation of a lead professional from among the agencies that remained involved. This should have been considered as an outcome of the local authority assessment.
- 3.2.10. As all of the agencies had found the mother difficult to engage it would have helped to agree arrangements to share information between agencies. This might have highlighted some of the discrepancies in the information provided by the family. A recommendation is made in relation to this.

Actions member agencies and the LSCB should take

- 3.2.11. Overall there was insufficient clarity about the means by which concerns arising in the antenatal period are identified, assessed and referred. The Care Quality Commission conducted an inspection of health services for children in Wolverhampton while this case review was

taking place. This found comparable shortcomings in a range of cases. There was also a lack of leadership in relation to safeguarding. As a result the pathways for recording and acting on concerns were not clear.

- 3.2.12. The review has been made aware that multi-agency, pre-birth pathways have been revised, including those that deal with concerns that do not meet the threshold for child protection and therefore require collaborative working between health professionals, children's centres and agencies working with parents (such as mental health services, the YOT).⁵ This followed the findings of a Serious Case Review published in 2013. WSCB now needs to ensure that this work is being implemented effectively by all those working with pregnant women and their families.

3.3. Quality of social care assessment, management oversight and the impact of organisational change

Evidence identified by the SCR

- 3.3.1. A community midwife passed information about the mother of Child F to the local authority on 21 April 2015. A member of the central referral team had further phone contacts with the allocated midwife and with Child F's mother. Drawing this together with information about the mother's previous contact with the local authority, a manager in the team decided that the referral should be allocated for a pre-birth assessment. Responsibility was transferred to the locality social work unit with a decision that a visit should be made the following week.
- 3.3.2. The initial screening identified concerns in two areas: the way in which Child F's mother had presented herself during appointments with midwives and also possible risks that might arise from contact with the known sex offender. The circumstances were viewed as potentially very concerning, suggesting that there might be a need for strategy discussion and even a legal planning meeting if the assessment raised doubts about the ability of the family to protect the baby when born.
- 3.3.3. The assessment visit was made on 12 May 2015 by the consultant social worker who was the manager of the locality unit but also undertook some direct work. The delay was due to the unit workload. Prior to this the manager had had further phone contacts with the midwife, provisionally scheduling a child in need meeting to be held on 18 May 2015.

⁵ WSCB Interagency Protocol for Unborn children and young babies (2016)
https://www.wolverhampton safeguarding.org.uk/images/safeguarding-children/children-documents/WSCB_Inter-agency_Protocol_for_Unborn_Children_and_Young_Children_May_2016.pdf

- 3.3.4. At the assessment visit the manager formed the view that the mother had a good network of family support, stable housing and that she was in receipt of the right state benefits. She had now attended her dating scan so the expected date of delivery was known.
- 3.3.5. Child F's maternal grandmother denied that she had any contact with the sex offender and said that she believed he was now dead. The social work manager expressed reservations about the grandmother's capacity to support her daughter during the pregnancy and in caring for a baby. Child F's mother again refused to identify the father of the child, this time giving a different name to the one previously given to the central referral team.
- 3.3.6. On the basis of this visit the social work manager decided that no further action was required by the local authority and made a decision to cancel the proposed child in need meeting. The midwife was told this on the day of the proposed meeting. She also told the social worker that mother had been referred to the Family Nurse Partnership (FNP). The midwife was asked to re-refer the case to the local authority if there was a significant change in circumstances.
- 3.3.7. Although this assessment visit was undertaken in May 2015 the assessment was not written up and authorised by another manager until mid-August 2015. The write up noted that the mother had been referred to the FNP, though by then she had declined contact with the service.
- 3.3.8. This was a weak assessment, given the referral and the circumstances. It relied almost exclusively on the account given by Child F's mother and grandmother, without making wider checks of the network or reviewing the history of local authority involvement. It did not explicitly address a number of the concerns identified in the original referral and central referral team management decision (such as the concerns about the mother's behaviour with other professionals). The assessment accepted that the convicted offender no longer posed a risk, because the grandmother said that he was dead, but there is no evidence that this was checked or that the information was shared with other agencies.
- 3.3.9. There had been a working assumption, on the part of the central social care referral team and the community midwife, that there would be some form of pre-birth meeting in order to coordinate the input of agencies and work together with the mother. This was cancelled with little information provided as to the reasons and without there being any clear plan as to how the agencies that remained involved would work together. There was a substantial delay in completing the assessment.

- 3.3.10. There were only limited attempts to identify the father. This should have been given more priority given the potential vulnerability of the mother. This is discussed further as it applied to all agencies in Section 3.4.
- 3.3.11. The final summary of the assessment is misleading in that it states that the mother had been referred to the FNP, whereas it was known that she had declined to be involved by the time the assessment was written up.
- 3.3.12. There was no proper management scrutiny of the assessment. The manager who reviewed and authorised it was relatively newly appointed to the authority and assumed that because it had been written by an experienced social worker / manager it would be satisfactory.

Why did this vulnerability in services exist?

- 3.3.13. The poor assessment was the result of both individual and organisational weaknesses. In 2014 Wolverhampton adopted a 'new operating model' for its local authority social care service. It was inspired by the Hackney model of social work though it had only very limited similarities with the original.⁶ Wolverhampton City Council created a highly decentralised model of 16 locality units each with a consultant social worker, a small number of social workers (usually three) an unqualified practitioner and an administrator. These units were responsible for managing work from the receipt of a referral from the central referral team and would include child protection investigations, child in need assessments, responsibility for children who were subject to child protection plans and some court work. Children looked after long term were the responsibility of other teams.
- 3.3.14. The advantage envisaged for such local teams was that they offered children and families fewer changes in allocated social worker as well as the capacity for social work units to form strong links with early help services and other professionals in a small geographical area. The disadvantage of this arrangement is that teams become very vulnerable to gaps in staffing and shortcomings in the quality of workers. Changes in referral rates and the intensity and difficulty of work also have a direct and disproportionate effect on small teams. This was recognised and in early 2015 senior managers in Wolverhampton made a decision to merge locality units, halving their number in order to reduce these risks.
- 3.3.15. The social work unit dealing with Child F's family was a busy one traditionally carrying a large number of adolescents and pre-birth assessments. The current manager describes 'a lot of CSE concerns and

⁶ Steve Goodmann and Isabelle Trowler (2012) Social Work Reclaimed, <http://www.jkp.com/uk/social-work-reclaimed.html>

a lot of domestic violence referrals.... a lot of the young parents have had child protection concerns as part of their background or have been looked after'. At this time and like other authorities in the West Midlands, Wolverhampton relied to a substantial degree on employing agency workers. From late 2014 onwards the unit experienced gaps in staffing and shortcomings in the quality of some social workers. As a result a backlog of assessments and case allocations built up and the unit manager was forced to allocate many assessments to her own caseload.

- 3.3.16. By April 2015 when Child F's assessment was undertaken the team was fully staffed. However this assessment remained as part of a backlog that was only completed in August 2015. A number of assessments remained subject to delays, or were written up some time after the visits had been made. In some cases children were allocated as children in need prior to assessment visits having been made. This hid the difficulties in the team from more senior management oversight because it gave the appearance of reducing the number of children whose assessments were overdue.
- 3.3.17. Some of these practices were only identified in mid 2015 when the incumbent agency manager was replaced with a newly appointed permanent member of staff who became responsible for this this now happening?wo merged social work units. Discovery of the extent of the difficulties was delayed because there was no proper handover between the two managers.

Actions member agencies and the LSCB should take

- 3.3.18. The quality of the assessment undertaken in this case fell short of the standards which the local authority and the LSCB expect. The SCR is not in a position to provide reassurance about the wider quality of assessment, and pre-birth assessment in particular, either at during the period under review or subsequently.
- 3.3.19. The local authority now undertakes sample auditing across children's services focused on referrals and assessments and the quality of visits. The review will recommend that further the audit programme is developed to take account of the specific learning from this review.
- 3.3.20. The role of the LSCB in relation to wider organisational issues are referred to further in section 3.8.

3.4. Identification of fathers and the links between services working with different family members

Evidence from the SCR

- 3.4.1. The identity of the father of Child F remained unconfirmed until the criminal investigation.

- 3.4.2. Early in the mother's pregnancy community midwives noted concerns about a young male who attended a number of appointments with the mother and was described as being immature and disruptive. They were concerned about him and reported this to the local authority as part of the referral. During visits family members told the midwife that person was a local youth who suffered from behavioural and learning problems. Later family members specifically denied that this young person was the father of Child F.
- 3.4.3. The mother gave the central social care referral team a shortened version of the name of the father but refused to give more details. On the assessment visit the family gave the social worker another, abbreviated name but no details.
- 3.4.4. The YOT was working closely with the mother. Her response to enquiries about the father was to mislead professionals, saying that that it had been a brief relationship and that Child F's father did not want to be involved.
- 3.4.5. At the primary health visit (new birth visit) a man presented himself as the mother's cousin, and was actively involved in caring for the baby, but denied being the child's father baby. This aroused some concern but there was no further opportunity to follow this up before Child F was injured.
- 3.4.6. The probation service worked with the father and became aware that he had a partner who was pregnant. No attempt was made to identify her. As the father had a history of sexual allegations against children his risk assessment should have been updated when he made it known that he was having a child, both to consider whether the plan for his probation supervision remained relevant and also to consider whether he might pose a risk. This finding echoes earlier learning for the service from an internal management review of a case in which there had been insufficient curiosity about a young man's links to children.
- 3.4.7. In the health service, similar shortcomings in work to identify fathers and male carers were identified by the 2016 Care Quality Commission CQC Review of Safeguarding Children and Services for Looked After Children July 2016. This found that when father's details were recorded there was no evidence of staff evaluating their role in depth.
- 3.4.8. Had the father been identified, and had this information been shared between agencies, it is likely to have altered the perception of risk and may have led to different steps being taken to assess risk and coordinate service provision.

Why did this vulnerability in services exist?

- 3.4.9. Child F's mother and her family deliberately withheld information and misled agencies about the identity of his father. It has not been possible

to establish their reasons for doing so because they did not contribute to the review.

- 3.4.10. Despite the concerns about the mother's reticence to identify the father and the concerns about the young man who attended some appointments, agencies made only limited efforts to identify the father. Reasons for not doing so were not recorded. It is therefore not clear what priority agencies give, in practice, to the identification of fathers, male carers and family composition.

Actions member agencies and the LSCB should take

- 3.4.11. The value of identifying fathers and male carers has been stressed in research and the findings of SCRs. Often when fathers are identified, little is found out about them.⁷ Government has promoted the idea that professionals should 'Think Family' in which 'services working with both adults and children take into account family circumstances and responsibilities'.⁸ However there is a danger that this can become merely a slogan if the practical difficulties of implementing this philosophy are not worked through with and by front line staff.
- 3.4.12. There is also a tension in public policy over this. Professionals are expected to engage male partners in discussions and assessments while at the same time to exclude men from some appointments in order to create a 'safe space' where women can discuss concerns about domestic abuse.
- 3.4.13. The review has concluded that existing strategies to promote the 'Think Family' approach among professionals in Wolverhampton and to increase the involvement fathers and male carers have not been successful and need to be reviewed. WSCB could usefully consider how much it understands about practice in relation to this and how agencies help their staff resolve these difficulties.

3.5. The role of the new birth visit and the lack of information about the family background

Evidence identified by the SCR

- 3.5.1. The new birth visit was made six days after Child F was discharged from hospital and the day after his first visit to the Emergency Department. It coincided with a visit from a health care assistant from the midwifery

⁷ Marian Brandon, Pippa Belderson, Catherine Warren, David Howe, Ruth Gardner, Jane Dodsworth, Jane Black (2008), Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious case reviews 2003–2005, Department for Children Schools and Families

⁸ Social Care Institute for Excellence, 'Think child, think parent, think family: a guide to parental mental health and child welfare', <http://www.scie.org.uk/publications/guides/guide30/introduction/thinkchild.asp> , website accessed 7 November 2016

service. This meant that Child F was weighed on the same occasion. The timing of the visit fell well within local health trust policies.

- 3.5.2. The visit is described in Sections 2.28 – 2.31 above. It addressed all of the areas of maternal and infant health that are expected. Hearing tests could not be carried out but were scheduled to take place on a follow up visit. The health visitor planned two follow up appointments in line with the health trust's expectations. Child F had been seriously injured before the follow up visits could be made but there is no suggestion that anything untoward was missed during the appointment.
- 3.5.3. The health visitor was not in a position to take full account of the range of social and environmental factors that might have affected the care of Child F. Although it had carried out a pre-birth assessment the local authority had not provided background information about the mother and her family. The antenatal service had provided only limited information about concerns identified in the pregnancy, despite the services being part of the same health trust. There had been no antenatal visit by the health visiting service as these were strictly rationed at the time.
- 3.5.4. Reservations about the young man who had attended antenatal appointments were not known. This is likely to have been due to the number of midwives who saw the mother, with neither of those involved in identifying concerns early on in the pregnancy remaining involved during the later stages. Concerns also diminished during the last ten weeks of the pregnancy.

Actions member agencies and the LSCB should take

- 3.5.5. It is not clear if the health visitor would have acted differently if more information had been available, but in other cases the sharing of such information will be important.
- 3.5.6. National guidance currently sets out the schedule of visits and developmental checks currently made by GPs and health visitors as part of the Healthy Child Programme.⁹ There are discussions nationally about the future of the programme and suggestions that the requirement to make all of these visits may be removed or amended.¹⁰ Some commissioners and providers already offer a local interpretation of the guidance based on a smaller number of routine visits.

⁹ Department of Health (2009) Healthy Child Programme: Pregnancy and the First Five Years of Life

¹⁰ Children's public health 0-5 years – review of mandation letter from Public Health England, 28 June 2016, PHE Gateway number: 2016-106, <http://docplayer.net/21420907-29-june-2016-phe-gateway-number-2016-106-dear-colleague-re-children-s-public-health-0-5-years-review-of-mandation.html>

- 3.5.7. Particular importance is already attached to the scope and value of the primary health visit as it plays a significant role in determining the number of further visits made and the nature of the contact between the child and health professionals. In this context it is particularly important that the health visitor is as fully informed as possible about any relevant risk factors. An antenatal visit would have been beneficial in this case.
- 3.5.8. Wolverhampton Public Health has circulated a revised service specification for the Healthy Child Programme. Given the key role of the primary health (or new birth visit) and the potential value of antenatal visits WSCB should ensure that it understands as much as possible about the quality and effectiveness of primary health visits. A recommendation is made in relation to this.

3.6. Safeguarding arrangements in the district general hospital Emergency Department

Evidence identified by the SCR

- 3.6.1. Sections 2.26-27 and 2.33-35 describe the provision made when Child F's parents brought him to the Emergency Department (ED) on two occasions, four days before the injuries that caused his death and one day before.
- 3.6.2. On both occasions he was examined and found to be well. On the first occasion a plan was made to admit him overnight for observation to eliminate the possibility of an infection. His parents took him home before he could be admitted but a midwife found him to be in good health when she visited the home the following day.
- 3.6.3. At the second ED attendance Child F was found to be well but an appointment was made the following day for him to be brought to a follow up clinic because the view was that the parents were inexperienced and anxious and would benefit from reassurance about the baby's health. They did not bring Child F to this appointment. The hospital arranged for information about the ED attendance to be shared with health staff working in the community but no arrangements could be made for a follow up visit at home before Child F was injured.
- 3.6.4. Section 3.1 of the report has scrutinised these episodes to determine whether evidence that Child F had been injured or was at risk should have been identified during these visits.
- 3.6.5. While there is no evidence that the injuries that caused Child F's death could have been anticipated, evaluation of the two attendances highlights shortcomings in the arrangements for safeguarding children in the ED. These reflect difficulties in practice (described below) that have been found to exist in other emergency departments, though that does not diminish the importance of addressing them locally.

Experience and training of staff and the accessibility of guidance documents

- 3.6.6. There were variations in the training in safeguarding and in the level of experience of the staff involved in dealing with Child F.
- 3.6.7. The paediatric nurse who agreed to the discharge of Child F during his first visit was on a rotation to the ED and had very limited experience and training. She had received no induction to working arrangements in the ED and would have benefited from more mentoring which she had found was not possible within the resources available.
- 3.6.8. The nurse was unsure of the procedures relating to parents discharging a child and who she should consult. It is to be found on the hospital intra-net but more experienced staff, including one ED consultant, recognised that they had not known where the guidance on discharge of children against medical advice was located until after this incident.
- 3.6.9. The junior doctor who examined Child F had limited paediatric experience and had not undertaken level three safeguarding training (which is required of all ED staff). Other staff involved were very experienced (including some of the most experienced in the department) and had received the relevant safeguarding training. However they gave different accounts of the safeguarding training that is provided for ED staff, how successful and well attended it is. A recommendation is made in relation to this.

General safeguarding awareness

- 3.6.10. All of the staff who had seen Child F conveyed clearly to the review that they were mindful of possible safeguarding concerns when they saw him. However this general awareness was not always matched by detailed interrogation of possible risk factors which was in turn not supported by the hospital's systems. Staff were overly reassured by the fact that the clinical examination found no evidence of pain or injury and insufficiently aware that (for the reasons set out in Section 3.1) an injury in such a very small child might be asymptomatic. The inconsistent accounts of Child F's injury (see Section 3.1.5 above) should have been addressed more explicitly.
- 3.6.11. Insufficient attention was given to the fact that this was Child F's second ED attendance in the first two weeks of his life. The review knows of no solid data on ED attendance among such small children against which to benchmark this; however the double attendance in this case is possibly very unusual. During this visit the parents made very specific references to events that they said had happened in the pregnancy and delivery which they said were relevant to the reported leg problem. These notes would have been easy to access and on this occasion staff would have had time to review them, but this was not considered because it was not customary practice in the ED.

- 3.6.12. At the time of this incident reliance was being placed on asking to return to attend review clinics with a paediatric ED consultant. Whilst this had been presented as being a 'safety net' it may have had the effect of placing less onus on those working in the ED to address possible safeguarding concerns. Similar reliance was being placed on the liaison health visitor role to ensure that possible safeguarding concerns were followed up by staff in the community rather than explored in the ED.
- 3.6.13. Interviews with consultant staff suggested that approaches to safeguarding varied between 1) general ED consultants (not paediatricians) 2) paediatricians working in ED because of their interest in and specialist knowledge of trauma working and 3) paediatricians working outside the ED with a specialist interest in safeguarding.
- 3.6.14. This has affected practice but will also have an impact on future steps taken to improve safeguarding. For example after the episode under review the ED introduced a template prompting steps to be taken by staff, such as checking old records and noting the number of recent ED attendances. This was referred to as the safeguarding 'stamp' because it is printed on top of the ED records. Although the intention was to introduce clear and specific procedures and thresholds, staff interviewed offered different perspectives as to its value, how often it would need to be used, which children it should apply to and how it would work. This interim measure and has now been superseded by a redesigned ED record for children. This demonstrates how any proposed solution always need to be understood by those who will need to use it, tested in practice, reviewed and improved.

Wider difficulties that are inherent to the task of safeguarding children in an Emergency Departments

- 3.6.15. The sorts of difficulties highlighted in this ED are not unique. Nationally there has been research and discussion about the difficulties that exist in EDs over the recognition and management of possible child abuse.¹¹ Such difficulties are inherent to the problem of identifying and managing child abuse in an ED. These arise from a number of factors including the following:
- Cases of child abuse are difficult to diagnose
 - The skill of raising concerns with parents is a difficult one to master
 - Apparently minor injuries may be very significant, but most injuries to small children are not the result of abuse
 - Professional intervention relies on collaborative working with colleagues in a number of specialisms and departments and may

¹¹ Sue White et al, 'Improving practice in safeguarding at the interface between hospital services and children's social care: a mixed-methods case study', Health Services and Delivery Research, Volume 3, Issue 4 February 2015

make substantial demands on their time (ED consultants, nurses, ED paediatricians and other paediatricians, orthopaedics and radiography)

- 3.6.16. Researchers have highlighted the perceived tension between what they term 'precautionary' and 'proportionate' approaches. The former underline the grave potential consequences of child abuse while the latter recognise that relatively few cases of the very large number of children's attendances are the result of abuse and that most children's injuries have benign or accidental causes. It is likely that these standpoints may have underpinned some of the views expressed by staff in the ED.
- 3.6.17. The research has demonstrated that because behaviour among staff in EDs is shaped by these complex factors it cannot be modified simply through the introduction of procedures which make specific actions mandatory. In some instances when apparently 'clear' and 'strict' procedures and protocols have been implemented, usually in accord with the wish to develop a precautionary approach, compliance with them is low (less than 50%) because they lead to other unforeseen difficulties (or perceived difficulties) such as overload on other colleagues or a large number of referrals that prove not to be confirmed cases of abuse.¹²

Actions member agencies and the LSCB should take

- 3.6.18. Since the events that are the subject of this review, the Care Quality Commission has undertaken a review of the health trust's provision for children and young people, including the ED. Its immediate feedback pointed to shortcomings in services in the following areas: lack of training and awareness; poor record keeping, not assisted by systems and format; a lack of supervision oversight of the quality of safeguarding work, including multi-agency work. Many of the findings mirrored the concerns identified in relation to Child F.
- 3.6.19. As a result the trust has been developing a substantial plan of action proposing the development of a range of tools and formats for staff, protocols, training and supervision.
- 3.6.20. It is unlikely therefore that the SCR could make recommendations that would add substantially to the changes that are proposed in these areas. It should be noted that patient safety initiatives are likely to be most successful when they take full account of the experience of front line staff in design and implementation and when there is strong

¹² In one hospital White et al found a compliance rate of 45%, even after the implementation of a highly publicised initiative to refer children under the age of one with head injuries for further assessment (White et al, op cit, page 35)

leadership from senior managers at the hospital board level, engaging all divisions in the hospital.¹³

- 3.6.21. This report will make recommendations focused on the oversight and coordination of these initiatives by the safeguarding children board which should undertake a regular review of progress. It will also recommend that audit of practice in cases that have been in contact with the ED should form part of its own multi-agency audit programme.

3.7. Safeguarding of Child F after he had been severely injured

Introduction

- 3.7.1. The SCR was asked to consider whether any safeguarding concerns arose during the period between Child F being injured and his death.

Evidence identified by the SCR

- 3.7.2. Child F received paediatric intensive care at Birmingham Children's Hospital for just over four weeks before care was withdrawn in line with the agreement of the High Court. During this period his injuries, which it was known would cause his death, were the subject of a criminal investigation. Although his father was in custody, Child F's mother was granted bail and spent considerable periods of time at his bedside.
- 3.7.3. The steps taken to safeguard Child F during this period presented some difficult challenges, taking into account that he required intensive care; the criminal court had granted his mother bail conditions that allowed her the right to have contact with him but left open the question of how far she should be involved in his care. At the same time his mother was the subject of criminal enquiries. There was a need for a continuous presence of the police at the bedside in order to protect Child F while at the same time monitoring his mother's behaviour. Medical staff occasionally found this difficult. They also wanted to involve Child F's mother in his care on the basis that it would assist her in coming to terms with his death, which was always known would be inevitable.
- 3.7.4. Shortly after his admission to hospital a multi-agency meeting was organised. The local authority social work manager had relatively little time to prepare for this meeting and it did not provide a detailed plan for supervision of contact. This was provided by the police some days later.
- 3.7.5. Staff involved have told the review that this was an extremely unusual set of circumstances. It was recognised that it took a number of days to work up a detailed plan for contact arrangements because at the beginning of the admission it was not anticipated that Child F would

¹³ White et al, op cit

survive for such a long period of time. Had this been clear a plan would have been developed much sooner.

- 3.7.6. The review has noted that despite the difficulties social care, police and the intensive care ward sister and consultant kept in close communication and were able to address difficulties as they arose. Since the death the hospital and police have held a round table discussion to debrief over the issues. Although in hindsight they might have done some things differently staff involved should be commended for their management of a difficult and unusual set of circumstances and their willingness to talk through difficulties both during and after events.

3.8. LSCB oversight of the impact of organisational changes on local safeguarding services

Evidence identified by the SCR

- 3.8.1. Organisational factors had a negative impact on the quality of provision in a number of the services provided for Child F. They made it more likely that individual errors would occur, less likely that significant information would not be shared and less likely that errors would be spotted and rectified.
- 3.8.2. The social care pre-birth assessment was affected by the quality of some staff, the existence of backlog of work and the impact of changes being made to improve an organisational structure that had been found to have flaws. Detail is provided in Section 3.3.
- 3.8.3. The health visiting service was affected by shortages of staff and restructuring of services made so that services aligned with those of the local authority. It had limited capacity to carry out antenatal visits.
- 3.8.4. Midwifery provision suffered from shortages of staff leading to there being a large number of midwives involved with the mother. This may well have reduced the likelihood of early concerns being pursued later in the pregnancy.
- 3.8.5. The probation service had been negatively affected by its restructuring into two services, vacancies and staff sickness. This led to a large number of appointments being covered by staff providing duty cover working with clients who they did not know.
- 3.8.6. Staff in the Emergency Department have described an increased workload as a result of having assumed responsibility for a larger catchment area, with reduced opportunities for training and induction. The department was actively preparing for a move to a new building during the period of contact with Child F. However there is no evidence that the care of Child F was adversely affected because staff lacked time.

Actions member agencies and the LSCB should take

- 3.8.7. Taken together these changes will have had a significant impact on the quality of provision made in a range of cases, despite the efforts of staff and managers. It is noteworthy that there were parallel changes in a number of agencies, possibly in combination creating a greater overall effect.
- 3.8.8. The LSCB should therefore consider whether it has sufficient knowledge and oversight of significant organisational developments and their potential impact on service provision. If not , what steps can the board take to make itself more aware? The board should consider what steps it can take to mitigate the risks arising from pressures on services and organisational changes.

4. RECOMMENDATIONS

4.1. This section of the report sets out recommendations to individual agencies and to Wolverhampton Safeguarding Children Board. The actions for individual agencies focus on specific areas of practice and management. Actions for the board relate to its responsibility to monitor and challenge the performance of member agencies. Contributing agencies have made other changes in policies and practice during the course of the review. These are reported separately in the safeguarding board response to this review, published alongside this report.

Actions for individual agencies

4.2. Royal Wolverhampton NHS Trust should undertake a review of the safeguarding arrangements in the Emergency Department at New Cross Hospital addressing the following areas of practice and management:

- the engagement of all divisions in plans to improve the safeguarding work of the ED
- overall awareness of safeguarding and training (including induction training)
- standards in recording
- formats to facilitate good record keeping
- a 'think family' approach
- supervision and leadership.

4.3. Royal Wolverhampton Hospitals NHS Trust should undertake a review of the safeguarding arrangements in antenatal services including the following areas of practice and management:

- clear standards and procedures for safeguarding
- standards in recording
- formats to facilitate good record keeping
- a 'think family' approach
- supervision and leadership
- improved quality of referrals with analysis and clear identification of risks.

4.4. City of Wolverhampton Council should audit the quality and effectiveness of local authority child and family assessment, including pre-birth assessment.

4.5. City of Wolverhampton Public Health should ensure that the service specification for the Healthy Child Programme addresses the need to improve the quality of primary health visits, taking account of the need for GPs, antenatal services and health visitors to share information and to provide effective coordination of work with children and families.

4.6. National Probation Service (Midlands) should ensure that risk assessments are updated when there is a change in the circumstances

of a supervised offender which may indicate a heightened possible risk to vulnerable children or adults.

Recommendations for Wolverhampton Safeguarding Children Board

- 4.7. Wolverhampton Safeguarding Children Board and all member agencies should review the approach currently taken to providing information to new and prospective parents to ensure that it gives clear messages about the risk of shaking a baby and signposts sources of practical support.
- 4.8. Wolverhampton Safeguarding Children Board should review current responsibilities and pathways for pre-birth identification, referral and assessment of need in order to determine whether they are clear and well understood and that they are being implemented in the way that the board intends. Clear guidance is required on the use of the Early Help Assessment in the pre-birth period. This should apply to all agencies.
- 4.9. Wolverhampton Safeguarding Children Board should assure itself that the quality and effectiveness of child and family assessment carried out by the local authority meets its expectations, including pre-birth assessment.
- 4.10. Wolverhampton Safeguarding Children Board should audit and review the actions that member agencies take to involve fathers and male carers in safeguarding work, including assessments. This should apply across all agencies and reflect the board's 'Think Family' approach.
- 4.11. Wolverhampton Safeguarding Children Board should ensure that it understands as much as possible about the quality and effectiveness of primary health (new birth) visits and challenges the health commissioners and provider to make improvements if required.
- 4.12. Wolverhampton Safeguarding Children Board should review the effectiveness of the work of member agencies in relation to families who are proving difficult to engage.
- 4.13. Wolverhampton Safeguarding Children Board should ensure that it has a detailed understanding of all aspects of the action plan to improve the safeguarding of children in the Emergency Department at New Cross Hospital and the way in which it is being implemented. Audit of practice and outcomes in cases that have been in contact with the Emergency Department should form part of its own multi-agency audit programme.
- 4.14. Wolverhampton Safeguarding Children Board should develop a strategy that will provide better knowledge and oversight of significant organisational developments in member agencies and their potential impact on service provision. The board should actively consider what steps it can take to mitigate the risks arising from pressures on services and organisational changes.

Appendices

Appendix 1	Terms of reference and details of lines of enquiry
Appendix 2	Principles from statutory guidance informing the Serious Case Review method
Appendix 3	How the review was undertaken
Appendix 4	SCR review team and panel members
Appendix 5	Roles of staff interviewed
Appendix 6	References

Terms of Reference and details of areas to be considered by the review

1 Overall purpose and terms of reference

The purpose of the review is to undertake a '*rigorous, objective analysis...in order to improve services and reduce the risk of future harm to children*'. The LSCB is required to '*translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children*'.¹⁴

The specific objectives of the review are

1. To establish what happened
2. To establish why professionals acted as they did
3. To identify and understand the significance of a range of contributory factors that shaped the practice of professionals, including wider organisational factors.
4. To identify any episodes and background factors that may have a direct bearing on the injuries to Child F and therefore may be relevant to a consideration of whether or not the injuries could have been prevented.
5. In addition the review will seek to understand what the case history tells us about the strengths and weaknesses of local safeguarding arrangements (sometimes referred to as using the individual case as a 'window on the system').¹⁵
6. The review will explore aspects of the assessment of vulnerability, need and risk that it determines are relevant, whether any potential indicators of abuse and neglect were recognised and the provision that was made for the children and other family members.
7. The review will seek to establish whether the multi-agency working met the expectations of the LSCB for a case such as this. In particular did it enable a good overall assessment; coordinated support; identification of discrepancies in information given by the parents; provision of services to meet needs?

¹⁴ HM Government (2015) Working Together to Safeguard Children

¹⁵ Charles Vincent (2010) Patient Safety second edition

Appendix 2

Principles from statutory guidance informing the Serious Case Review method

The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed

Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

In addition Serious Case Reviews should:

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

Working Together to Safeguard Children 2015 (Sections 4.9 and 4.10)

How the review was undertaken

1. The LSCB compiled a chronology of key events based on the written and electronic agency records.
2. The LSCB established a review team to conduct the review consisting of the independent lead reviewer and senior staff from participating agencies and commissioners who had not been involved in the work with the family
3. Staff who had been involved in the work with the family and line managers attended a briefing session about how the review would be conducted
4. The review team held individual interviews with members of staff and managers, supported by review of records where this assisted
5. The lead reviewer drafted findings which were discussed with the review team on two occasions
6. After the criminal trial family members were again invited to contribute their experience of the services that they had received, but did not respond
7. The Serious Case Review Panel discussed and agreed drafts of the report and recommendations
8. Staff who had been involved attended a briefing about the findings of the review and asked to comment on recommendations.
9. The report was submitted to the safeguarding children board for discussion and agreement

SCR REVIEW TEAM MEMBERSHIP

Independent and WSCB members	
Keith Ibbetson	Independent Lead Reviewer
Business Manager	Wolverhampton Safeguarding Children Board
Administrator	Wolverhampton Safeguarding Children Board
Review Team	
Agency	Designation
Wolverhampton Clinical Commissioning Group	Designated Doctor for Safeguarding and Consultant Paediatrician
West Midlands Police	Detective Chief Inspector (Public Protection)
City of Wolverhampton Council	Principal Education Psychologist
City of Wolverhampton Council	Head of Safeguarding
Coordinator of Youth Organisations Wolverhampton	Voluntary Sector Council and WSCB

Roles of staff interviewed

City of Wolverhampton

Children and Young Peoples Service

Consultant Social Workers

Senior Consultant Social Worker

Service Manager

Youth Offending Team

Youth Offending Officer

Youth Offending Team Operations Manager

West Midlands Police

Senior Investigating Officer

Royal Wolverhampton Hospitals NHS Trust

Health Visitor

Team Leader Health Visiting Service

Paediatric Consultants in Emergency Department

Emergency Department Consultants

Junior Doctor Emergency Department

Emergency Department Staff Nurse and nurses

Paediatric Liaison Health Visitor

Community and Hospital Midwives and Support Worker

Senior Midwife

Birmingham Children's Hospital NHS Foundation Trust

Consultant Paediatrician

Ward Sister

Probation National Service (Midlands Division)

Probation Services Officer

Senior Probation Officer

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