Northamptonshire Safeguarding Children Board

Serious Case Review

Conducted Under
Working Together to Safeguard Children 2013

Child N

Overview Report

Lead Reviewer:
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June 8th 2015 (final)

SCR Child N

Date of birth: February 2014
Date of serious incident: March 2014
Ethnic origin: White UK

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1. INTRODUCTION AND BACKGROUND TO THE REVIEW

1.1 This Serious Case Review (SCR) was commissioned following serious injuries sustained by a young child when she was aged five weeks old. It considers the circumstances in which these serious injuries occurred and whether the services, which were received by the family from a range of professionals, provided the best response required to address her needs.

1.2 All names have been anonymised and the child is known as Child N within this review**.** Child N was born in February 2014. When she was five weeks old, she was rushed to hospital in a "floppy" state. Her condition rapidly deteriorated and resuscitation, intubation and ventilation were required. It was subsequently identified, through X-Rays and scans, that she had sustained bilateral subdural haemorrhages, two rib fractures, a leg fracture and a wrist fracture; the medical evidence is that these injuries had been sustained over a period of several weeks. As a result of these findings, a police investigation was initiated as the injuries were believed to be as a result of non-accidental injury. Her parents were arrested and were charged with allowing and causing significant harm to a child.

1.3 Child N has survived these injuries and she has made some limited recovery but it is clear that she will suffer lifelong disabilities and will never make a full recovery. A Serious Incident Review was undertaken at the hospital following the identification of Child N's injuries. Care proceedings for Child N have now been concluded. Both parents were charged with causing or allowing harm to a child and both parents pleaded guilty. Sentencing took place on 7th December 2016 and both parents are now serving custodial sentences.

1.4 These factors led to the decision on 5th June 2014 by the Chair of the Northamptonshire Safeguarding Children Board (NSCB) to undertake a Serious Case Review. The Working Together 2013 criteria for commissioning a SCR were met as follows:

"The child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child."

2. THE REVIEW PROCESS

2.1 This review has been conducted with due regard to the principles of fairness, impartiality, thoroughness, accountability, transparency and above all with a focus on the child, Child N. Consideration of her interests and experience have been the central focus of the review. The significance of the serious injuries she suffered and of the long term impact on her has affected all those involved in the review.

2.2 The time period covered within this Serious Case Review is from May 1st 2013 to 31st May 2014. Any additional historical information relevant to the review going back beyond these dates (e.g. within the parents' own childhoods) has been fully considered in the review.

2.3 Moira Murray and Amy Weir, who are experienced independent safeguarding experts, were appointed Independent Reviewers. A Panel of Senior Managers was formed to support the process. The Panel was chaired by Moira Murray, and Amy Weir wrote this report with the support of the SCR Panel. Further information about the Reviewers and the Panel is set out in the appendix.

2.4 The full Terms of Reference for the review are appended to this overview report. Critical points in the case were considered in the SCR. Possible reasons for actions taken at the time and learning and improvements needed have been identified, including the significance of these insights for current practice.

These findings will inform the NSCB's Learning and Development Plan and they will be embedded in local practice through that plan.

2.5 This investigation has examined key documents and spoken to key staff and practitioners, directly and indirectly through the involvement from each agency of experienced Senior Managers, who have had no direct involvement in this case. Local practitioners have been brought together to consider, discuss and comment on the findings of the review. The root cause analysis "fishbone" approach to identifying key contributory factors has been used. The aim of this has been to gain an understanding of how the interaction between various factors influenced the way practitioners responded to Child N and her family.

2.6 Child N's Mother and Father have been contacted to inform them that this review was being undertaken. They have also been asked whether they would like to contribute to the review. At the time of writing, they had declined to participate as they are preoccupied with the care and criminal proceedings which were in process. Both parents then pleaded guilty to the criminal charges and declined to contribute to this process.

2.7 The critical points considered are:

- What information, prior to and following Child N's birth, was known about the mental health of both her parents? Was this information effectively shared between agencies? A safeguarding 2 (SG2) form was completed by the Midwife, was this document shared effectively with other agencies?
- What early intervention services were provided to support the parents and protect the unborn child?
- In early March 2014, Child N was brought to the Emergency Department of Hospital A and was admitted with a painful right leg. No obvious fracture was identified and she was discharged two days later. Were the X-rays taken at that time reviewed by a Paediatric Radiologist? Was a differential diagnosis considered? Why was a referral not made to Children's Social Care at that time?
- Child N had six admissions to hospital over a period of 5 weeks from the time of her birth until she was admitted to hospital with life threatening injuries. Was a chronology made of these admissions and were health professionals alert to the safeguarding concerns presented? What was the process for paediatric review of the case and was it consultant led?

2.8 The possible reasons for actions taken or not taken at the time were considered:

- What factors contributed to practice decisions at the time?
- What could have been improved?
- Was consideration given to differential diagnosis and the possibility that Child N may have been subject to non-accidental injury or "Fabricated or Induced Illness" given the large number of hospital admissions in such a brief period?
- It is known that in the past that Father had been subject to Child Protection plans and that he had fathered a child with a mother who was 15 years old when she gave birth. What information was known to agencies about Father's history and his parenting capabilities?
- What level of safeguarding children training had professionals involved with Child N and her parents undertaken, and how did that training inform decisions taken at the time?

2.9 The significance of these insights for current practice.

- If the same event occurred now, what factors would influence the response?
- What learning and improvements have already been implemented?
- What is working well now and what still needs to be improved?

3 SUMMARY CHRONOLOGY

Date	Event
8th Feb 2014	Child N born.
10th to 11th Feb 2014	**In Hospital** - Jaundice admitted to Hospital A, treated.
12th to 14th Feb 2014	**In Hospital** – Re-admitted to Hospital A with jaundice. Feeding problems.
6th to 8th March 2014	**Hospital admission: Parents called 111** mentioned Child N having leg pain for 2 or 3 days and they also mentioned previous bruises. They were advised to contact out of hours GP – they again mentioned painful leg but not bruising and they were asked about any possible injuries. Seen with a limb injury by **out of hours GP** in early hours who considered possible medical cause (including dislocation of hip) as well as non-accidental injury as a possibility and he referred to Hospital Paediatrician. Mother spoke of her own congenital hip dislocation at birth. GP noted this but also possible leg break, perhaps non-accidental injury. Baby in pain when touched. 05:40 Admitted to Hospital A Paediatric Ward. Paediatric and orthopaedic staff involved. Initially both non-accidental injury as well as medical causes were considered. Mother's congenital hip problems were to be ruled out prior to referral to out of hours' Social Worker, if non-accidental injury remained a concern. 6th March X-Ray and 8th March, ultrasound on hips and knees, nothing abnormal was seen. Health Visitor informed by phone of event. Tests for infection showed none was present.
8th March 2014	Child N reviewed on ward - fracture or infection ruled out; safeguarding concerns not obviously revisited. Discharged from Hospital A. Parents advised to return if concerned and further scan to rule out hip dislocation to be completed on 13th March. Health Visitor contacted.
9th to 10th March 2014	**In Hospital** – 999 Breathless / apnoea incident observed by parents at home. Parent said baby went blackish purple in the face and stopped breathing for a few seconds. 23:37 Re-admitted to Hospital A Paediatric Ward *with apnoea after a feed - stopped breathing.* Health Visitor informed who then called mother on 10th March.
10th March 2014	After observations, no further apnoea incidents seen; stable so discharged at 14:00 Parents shown how to carry out basic life support. Cardiac Echo Test to be completed at Outpatients. Letter to be sent to the Health Visitor.
12th to 15th March 2014	**Admitted to Hospital**: **999 call** - Father said to have found baby unresponsive, no appetite, vacant eyes, *won't stop crying and was going limp*. Call handler felt baby sounded in distress and in pain, and heard piercing screaming on 999 call. 19.45 Transferred to Hospital A. Ambulance staff found baby floppy/ unresponsive, apparently in pain, fast heart rate and low temperature. Admitted and given fluids and antibiotics for suspected infection. 21:30 Admitted to High Dependency Unit at Hospital A.
13th March 2014	Repeated blood samples and lumbar puncture. 09:55 Reviewed by Consultant - reflux medication, antibiotics, chase for cardiac ECHO, chest X-Ray and head ultrasound; the possibility of an intra-cranial haemorrhage was mentioned.

14th March 2014	Reviewed – continue treatment. 21:00 Father reported that baby had an episode of "going black in the face", "monitor showed heart greater than 200 and oxygen saturation at 70%". No staff saw this.
15th March 2014	Staff Nurse noted that Child N was having brief episodes of staring to the left and eyes flickering whilst feeding; this was also observed by Senior House Officer. Nothing further noted. 12:00 Reviewed on ward round – chest X-Ray showed "patchiness" of left lung but decision made that well enough to discharge with antibiotics. 12:20 Consultant saw parents and advised them to get more support from Health Visitor. 19:30 Blood cultures negative so discharged.
17th March 2014	**GP saw mother** for feeding problem - reflux - and discussed recent admission to hospital. Mother said baby now much better now.
18th March 2014	**Health Visitor 6 week developmental check** at GP surgery. Child N gaining weight, mother gentle with baby and good eye contact. Mother said she was on anti-depressants and said felt low when baby was unwell. Father raised no concerns but said he was epileptic and asthmatic. Baby on antibiotics for chest infection.
20th March to 10th April 2014	**In Hospital: 999** – limp and high pitch cry. 13:00 Injuries identified. Admitted to Hospital A, but then transferred out of county to Hospital B as her condition rapidly deteriorated. Critical condition and thought unlikely to survive. Parents' behaviour inappropriately jovial and lacking concern. Abuse considered and referred to CYPS in Northants but referral apparently not responded to immediately. Further referral made into the MASH on the afternoon of 20th March by Hospital A following further information from Hospital B.
21st March 2014	Hospital B carried out Specialist Imaging and informed Hospital A that Child N had an inter-cranial bleed which was potentially a result of abuse. Police involved and parents arrested.

4. NARRATIVE OF KEY EVENTS with EVALUATION OF THE WAY AGENCIES WORKED

4.1 Prior to Child N's Birth:

What information, prior to and following Child N's birth, was known about the mental health of both her parents? Was this information effectively shared between agencies?

What was known and was this shared appropriately?

4.1.1 There is a considerable amount of relevant information in the records of various agencies about Child N's parents. However, it is clear that this was not fully sought or identified by all agencies in the management of the case. The professionals involved with Child N's parents only identified low levels of concerns until Child N's non-accidental injuries became clear in mid-March. Both of Child N's parents were brought up in Northamptonshire. Some agencies had kept the historical information about the parents but, for example, in Children's Social Care, the full information no longer appeared to be available or readily accessible.

4.1.2 Both parents had very frequent contact with their GPs over the years. Significant information about both parents was available in the GP records. In particular, there was information about Father, which identified that he experienced emotional abuse and neglect in his own childhood.

This, together with some of the information about his Mental Health Service contacts, would, if known to professionals during the pregnancy and during Child N's first few weeks of life, have been very likely to raise concerns that he might be unable to parent his own child safely. However, much of this GP information was only available in the historical paper records still held by the practice but not used in routine care. In particular, in relation to childhood safeguarding concerns for Father, these were only reflected in the electronic record through a single reference to the Father being on what was then the Child Protection Register.

4.1.3 Information about the Father's mental health history was also available within NHFT Adult Mental Health records. This was made available to the review.

4.1.4 As mentioned above, Child N's Father had been, throughout his childhood, the subject of concerns about his safety and care. Two older siblings had been removed from the care of his parents by another Local Authority. Father and his Brother were on the Northamptonshire Child Protection Register on two occasions 1987-88 and 1995-96; this was as a result of physical abuse from his mother and of having been left with strangers by his parents whilst they went away on holiday.
Father found it difficult to cope at school, was described as having emotional and behavioural difficulties and exhibited some unpredictable, dangerous and cruel behaviour. In 2001, Father was admitted to hospital for a psychiatric assessment as result of concerns about his challenging behaviour.

4.1.5 In 2006, Father had sex with a 15 year old who became pregnant; Father has a daughter with whom he has no contact following concerns about his inappropriate behaviour. In 2007, he was sectioned under the Mental Health Act following an argument at home and because he reported hearing voices. He was released a day later but was expected to have continuing contact with Mental Health Services; however, he missed most of his appointments and was discharged. Father was prescribed anti-depressants at times by his GP and had reported hearing voices from an early age which reportedly sought to control him and had caused him to be violent.

4.1.6 Child N's Mother was known to Child and Adolescent Mental Health Services (CAMHS) as a teenager. In 2006, her mother reported that Mother was "out of control" and making threats to harm herself. Mother was subsequently diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD) and given medication to control this. She wanted to go to college and, before Child N's birth, was a student at a local University though she did not apparently get through her first year. She had experienced anxiety and depression for several years and received treatment from her GP and Mental Health Services for depression. After she met Father she became pregnant and they both stated to professionals that Child N was born as a planned pregnancy.

4.1.7 At the Midwife booking in July 2013, both parents revealed their history of depression and of involvement with Mental Health Services. However, they did not share their full history of childhood difficulties nor that Father had another child. It is possible, if contact had been made by the Midwife or the Health Visitor with Mental Health Services, that Father's own troubled childhood, having been on the Child Protection Register, and the fact that he had fathered a child, may have come to light.

Was the information shared appropriately and acted upon?

4.1.8 Both the parents disclosed some information about their mental health histories when Mother booked with the Midwife early in her pregnancy. The potential for increased vulnerability was appropriately recognised. The level of concern did not reach a safeguarding threshold where, for example, information held by other services might be shared without parental consent.

In the Health Visitor Service, the history of mental health concerns caused the case to be classified at Level 2, "Universal Plus", potentially requiring additional services or support. Approximately 10% of the health visiting caseload in Northamptonshire is managed at this level.

4.1.9 Several previous case reviews nationally and locally have found that Universal Health Services often fail to establish a full picture of the concerns and vulnerabilities for prospective or new parents, which are available within all the person's health records. The history of fathers is also often insufficiently explored. There are a number of possible reasons for this:

- Recording templates and practice standards do not strongly support or promote the routine exploration of issues such as the parental relationship and parents' own childhood experiences. It appears that, as both parents presented no active concerns during the pregnancy, no further detailed enquires were made. The parents appeared to behave appropriately and seemed very committed to the pregnancy, made good preparation for the baby and provided good physical care to Child N when she was born.
- Current practice expects that midwives can access GP records for mothers, their primary clients. Universal access to fathers' records (bearing in mind that fathers may be registered at a separate GP practice) is not current practice. A pilot process is currently underway within Northamptonshire to see whether a universal approach to seeking consent to review the records of the father or partner is practical.
- Multi-disciplinary team (MDT) review meetings (typically including GPs, HVs and Midwives) had been established, or were being developed, in both GP practices, with the aim of sharing concerns and monitoring progress for vulnerable families. This is recognised good practice in primary care safeguarding. The GP IMR suggests that GP Practice A may have considered Mother's case at their developing MDT. However, Mother then registered at Practice B (where Father had always been registered).

  There was no clear expectation in the handover that the case be discussed at practice B's MDT, and this never happened. However, the concern level in this case would only have been increased if the MDT led to the opportunity to review Father's GP record.
- As noted above, inactive concerns and, in particular historical welfare concerns for parents, are often summarised very briefly. Identifying historical concerns for the entire caseload, or even the approximately10% of the caseload recognised as having additional vulnerabilities, will be dependent on record systems which effectively summarise and highlight such concerns within the records.

4.1.10 The limited information which the Midwife and also the Health Visitor had – that both parents reported a history of mental health problems – was never shared with the Paediatricians assessing Child N during her hospital admissions and nor was fuller information sought.

4.1.11 There was no established process on the paediatric ward to obtain any information on parental vulnerabilities from the maternity records. Communication with the Health Visiting Team during Child N's admission with a painful right leg was not effective in communicating concerns. The possibility of non-accidental injury, which was recognised at the start of the admission, was not communicated to the Health Visiting Team. The contact on this occasion seems to have been treated by both services as a routine notification. There may have been an expectation on the part of the hospital that the health visiting team would share any information about their vulnerability, but this did not happen. Information about Child N's multiple admissions was not shared with the Health Visiting Team in a consistent and timely way. In particular, the Paediatric Liaison Service was not functioning effectively at this time and there was a lack of clarity about its role and what was being provided.

4.1.12 The Midwife rightly saw the parents as vulnerable and likely to need additional support; she completed a Health Safeguarding Notification (Form SG2) to signify that there would be a need for additional support. This was shared with the Health Visitor and the GP; it was also reviewed some weeks later and a plan made for support. However, none of these professionals appear to have considered making contact with Mental Health Services directly to check out what the Midwife had been told about the parents' contact with those services so that the full details of their history were not known; the Health Visitor works in the same NHS Trust as Mental Health Services but this contact was not considered or made. Although it is not a defined expectation that health professionals should explore a parent's mental health history with Mental Health Services, it would have been good practice and would have provided highly relevant information in this case. For the most part, the GP, Health Visitor and Midwife did work well together to share information prior to Child N's birth but they did not see the need to seek the further information which would have been available.

4.1.13 As the history set out above shows, there was significant and relevant history in relation to the likely parenting capacity of both parents and possible vulnerabilities. Unfortunately, the level of safeguarding concern was not reached which might have led to referral to children's social care. The fact that Mother and Father themselves withheld some relevant information and seemed to be coping and committed to the baby also is likely to have led professionals to take an optimistic and less enquiring approach.

4.1.14 Were effective Early Intervention Services provided?

The Midwife identified the likelihood of the family needing additional support and linked effectively with the Health Visitor and the GP. The GP saw Mother and Father and "oversaw" the pregnancy.

4.1.15 Plans to refer the family to a Children's Centre do not seem to have been progressed. The context was that no specific concerns were identified or noted about how they were coping and planning for the birth of the baby; they seemed to be highly committed to the pregnancy and responded appropriately when seen for ante-natal screening and were preparing for the birth of the baby. This is likely to have led to this referral for Early Help not being regarded as a high priority and it might even have been seen as unnecessary.

4.2 After Child N's birth

4.2.1 After she was born, Child N was admitted to hospital on six different occasions during the first five weeks of her life. Child N was in hospital on two occasions during February 2014 - 10th to 11th and 12th to 14th February – both these admissions related to her being jaundiced. This is a common condition post-birth and her parents appropriately sought and received medical advice. On 6th March 2014, Child N was brought to the Emergency Department of Hospital A, following a referral from an out of hours GP; she was admitted with a floppy and painful right leg; she was discharged on 8th and admitted again on 9th March before being discharged again on 10th March. She was next admitted to hospital from 12th to 15th March after a 999 call from her Father saying she had stopped breathing for a period and was unresponsive. Child N was also admitted to the hospital on 20th March when she was unresponsive and floppy and her condition quickly deteriorated to being critical.

Were the responses to Child N's hospital admissions appropriate and were effective services provided?

4.2.1.1 Admission March 6th to 8th 2014

- The first significant admission was on 6th March. Child N's parents phoned the NHS 111 telephone advice service late on the evening of 5th March. The summary record of this contact indicated that this problem had been a concern for a few days, and the parents had previously noticed some bruising. Parents were advised to take Child N to a GP, which they did. The out of hours GP would have had all this information including the bruising comment. It is not clear whether this information, which should have further raised concerns about possible non-accidental injury, was passed on to the hospital when Child N was admitted in the early hours of the 6th March. The out of hours GP provider has recognised that while arranging hospital admission was appropriate, safeguarding concerns should have been flagged to the patient's usual primary care team for follow up. An immediate referral to Children's Social Care could have been considered, and they have provided assurance that such referrals are made regularly.
- Both the GP and the admitting Paediatric Registrar appropriately recognised that non accidental injury was a possible explanation for Child N's painful leg. It was reasonable to consider possible medical explanations for the painful leg, but the conclusion that this was due to Developmental Dysplasia of the Hip (DDH), typically a non-painful condition, was inappropriate, but was undoubtedly influenced by Mother's own description of her history of DDH.
- Physical examination did not show any bruises or other external injuries, X-rays did not show any clear signs of fractures, and hospital staff had no concerns from their observation of the parents and the care they gave to Child N. Child N's painful leg should have been recognised as unexplained in such a young, immobile baby, and still potentially having been the result of non-accidental injury. We now know the fracture was present but was not picked up; if this had been seen, further steps could have been taken including a specialist paediatric review of the X-Rays, and a referral to Children's Social Care. There is a new NSCB Bruising Protocol which would now support a referral if the problem was recognised as a possible unexplained injury in a very young, immobile infant.
- Even if no further action to refer was taken at this time, a safeguarding flag in relation to an unexplained concern might have influenced thinking at Child N's subsequent admissions. Various tests were ordered and completed and a thorough medical assessment was made of Child N's condition without delay. Initially, as the out of hours GP had recommended, non-accidental injury as well as medical causation for her leg pain was considered. When Child N was examined, she had no visible injuries identified on X-Ray. She was discharged two days later without any further consideration of the possible safeguarding concern.
- We now know that subsequent X-Rays viewed by a specialist have shown a fractured tibia below the knee, and this is the most likely explanation for Child N's leg pain. Specialist review has identified subtle evidence of a possible fracture on the films taken during this admission on 6th March. The specialist consulted stated that the tibial fracture was "due to a forceful grab and yank type injury" involving the use of force well beyond normal handling. However, it is clear that this subtle abnormality at this stage could have been missed by Paediatricians and general Radiologists.

4.2.1.2 Admission 9th to 10th March

- Having been discharged on the 8th, Child N was re-admitted on the 9th of March. Her parents reported a "blue episode" at home. Child N's parents dialled 999 late in the evening saying that she had had a breathless / apnoea incident. Her Father said her face had been blackish / purple and she had stopped breathing for a few seconds. Child N appeared "well" on admission.

Tests were arranged to rule out infection. It was thought that Child N might have experienced an apnoeic episode (stopped breathing) at home; this is a relatively common problem in very young babies with a range of possible causes; the working diagnosis of reflux (of stomach contents into the oesophagus, also common in young babies) was reasonable. No X-Rays were taken during this admission. The previous concerns and issues do not seem to have been reviewed and non-accidental injury was not considered. No further apnoea episodes were observed in the hospital. The health visitor was notified of the admission when Child N was discharged the next afternoon; a further medical test – Cardiac ECHO was to be arranged as an outpatients appointment, as a heart murmur had been picked up on examination during the admission. She was discharged home on the 10th March.

4.2.1.3 Admission 12th to 15th March

- Child N was admitted once again on the evening of the 12th of March. Her parents had called 999, reporting that Child N was unresponsive, had vacant eyes, would not stop crying and was limp and floppy. The ambulance service reports that Child N had a high pitched scream throughout the emergency services call, and they felt she was very distressed at this point. By the time the ambulance crew arrived at her home, Child N was floppy and less responsive than normal. Her condition seems to have been much the same on arrival to hospital.
- Child N was immediately recognised as being significantly unwell and the immediate management, focused on identifying immediately treatable causes such as infection, was appropriate. Child N was cared for in the Paediatric Department's High Dependency Unit, until 14th March when her condition had clearly stabilised. A chest X-Ray was obtained soon after admission, with the request form indicating that infectious causes for Child N's illness were being sought. It has emerged subsequently that two rib fractures - most likely due to non-accidental injury, were not identified from the X-Rays taken at that time; from the X-Rays, her lungs were described as being "patchy"; this was assumed to be an indication of infection of the lungs and antibiotics were prescribed. The possibility of an intra-cranial haemorrhage was mentioned but not followed through as an indicator of possible non-accidental injury and the Consultant did not apparently think there was need for an ultrasound scan Although a Doctor and a Nurse noticed that Child N was briefly staring to the left and her eyes flickered during feeding – possible indicators of neurological trauma - these issues were not addressed or discussed with her parents prior to her discharge. Father reported during this admission that Child N "went black in the face" and that her oxygen saturation dipped, this does not seem to have been questioned or followed up either. It is important to note that these observations by Father were not seen by hospital staff.
- When Child N was discharged with antibiotics prescribed for her presumed chest infection, her parents were recommended to seek more support from the Health Visitor. By the time of Child N's discharge, no clear evidence of infection to account for her initial presentation had been found and the working diagnosis was once again apparently apnoea secondary to reflux; the evidence to support that view is not clear. Child N had been quite unwell and more consideration should have been given to possible alternative causes. If the rib fractures had been identified in the X-Ray film, this would have triggered a safeguarding response and most likely Child N would not have remained in the care of her parents, and not suffered her subsequent catastrophic injuries.
- Child N's X-Ray films during her admission were reviewed and reported by members of the Radiology Department who were general Radiologists, rather than Radiologists with specialist paediatric expertise or a paediatric interest.

Previously, there had been a Radiologist with paediatric special interest at the hospital but he had retired and no-one with equivalent expertise could be recruited, despite repeated attempts to obtain this expertise. This position is not apparently unusual in smaller general hospitals, and there is a recognised shortage of Paediatric Radiologists nationally.

There was a missed opportunity during this admission to identify non-accidental injury. If the rib fractures had been identified at that point, it is likely that the subsequent serious injuries to Child N could have been prevented by removing her from her parents' care.

4.2.1.4 Admission on 20th March

- At her last admission, Child N's condition deteriorated very quickly, she became critically ill and required life support intervention and transfer to Hospital B from the local hospital. On this last hospital admission, a previous fracture of the tibia and of her wrist were identified following further scans at Hospital B. Subsequent skeletal scans at the end of March 2014 showed that she had suffered several fractures of various ages.

4.2.2 Was a differential diagnosis considered? Why was a referral not made to Children's Social Care at that time?

4.2.2.1 Initially at Child N's first admission in March, non-accidental injury as a differential diagnosis was considered but not fully explored; the out of hours GP considered non-accidental injury and this was also initially looked at on admission to the Emergency Department. Thereafter, in subsequent admissions the differential diagnosis of non-accidental injury was not considered. Thereafter, referral to Children's Social Care would not have been considered as part of the planning since evidence of non-accidental injury had not been identified.

Was information shared appropriately and acted upon?

4.2.2.2 When Child N was being admitted to hospital during March 2014 with various symptoms, the hospital staff did not look at her mother's antenatal notes; there is no system in the hospital for automatically linking the antenatal notes for Mother to the post-natal notes for the child. Her parents were regarded as behaving appropriately. The hospital Midwife had information about the parents' mental health problems from their self-report but she was not aware of the admissions which occurred after she was no longer involved with the family.

The Health Visitor also had information about their mental health problems but, although on most occasions, she was kept informed of Child N's admissions to hospital, she was not notified of the 12th March one; although a letter was prepared to inform her of the admission, it was not sent as a result of an "oversight". There is a post of Paediatric Liaison Nurse which is responsible for linking between the hospital and the Community Nursing Services to ensure there is effective sharing of information when children are in the hospital. In this case, the Paediatric Liaison Nurse does not seem to have been notified of Child N's admissions and her role seems to have been unclear.

4.2.2.3 During the second admission from March 12th 2014 to hospital, a Doctor and a Nurse both observed that Child N seemed to have a period of staring to the left and eye flickering whilst she was feeding. They were both concerned and thought this should have been considered as significant but this information does not appear to have been referred on or considered more fully in the clinical assessment before Child N was discharged home.

Were effective services provided?

4.2.2.4 In the hospital, there was liaison between the Emergency Department, Paediatrics and Orthopaedics and the symptoms which Child N had were responded to without delay.

Appropriate tests were ordered and the possibility of infection was explored. At the first admission in March 2014 on the 6th March , it appears that non-accidental injury was briefly considered but this was discounted in favour of considering various possible medical diagnoses related particularly to mother's congenital hip problems but also to a possible heart problem on 9th March. The parents appeared to be appropriately concerned and did not arouse any suspicion.

4.2.2.5 During the third admission to hospital from March 12th, Father reported to the nursing staff that the baby had an episode of "going black in the face"; he said that the "monitor showed heart rate greater than 200 and oxygen saturation at 70%". No staff saw this and this was not questioned even though only Child N's parents had observed any evidence of apnoea then or prior to her admission to hospital. This should have been considered and explored more fully with both parents. During these admissions, Child N's parents showed some knowledge of "medical" matters, both of them referred significantly to their own illnesses. When provided with information about resuscitation, they both said they already knew all about that.

4.2.2.6 There is no indication that the need to consider abuse as a differential diagnosis was sufficiently considered. Doctors are required to consider familial / inheritable and medical causation for symptoms but this should not exclude keeping the possibility of abuse in mind.

4.2.3 Child N had six admissions to hospital over a period of 5 weeks from the time of her birth until she was admitted to hospital with life threatening injuries.
Was a chronology made of these admissions and were health professionals alert to the safeguarding concerns presented? What was the process for paediatric review of the case and was it consultant led?

Was information shared appropriately and acted upon?
4.2.3.1 As stated above, there were gaps and missed opportunities for the sharing of information. There was no system in the hospital for ensuring that the information and outcome from each admission was collated in a single record or chronology of episodes of care, and as a result, it was not possible to see any possible pattern. At each admission, the medical team were in effect "starting again". On each occasion the search began anew to seek medical or congenital reasons for Child N's condition. There was no one consultant with overall accountability as may be the system when a child is admitted with a longer term condition which requires follow up. In Child N's case, each episode was treated as a new single incident; the hospital needed to consider and define at what point an accountable consultant with clinical overview should be appointed for children with repeated admissions but this did not occur in this case.

4.2.3.2 The hospital service operates around the clock and inevitably several different clinicians and practitioners will be involved with the care of any child. Child N's case was reviewed on each admission and a senior doctor was responsible for assessing the situation and overseeing the decision to discharge. However, it is not clear who was case accountable or whether one of the clinicians retained an overview of her case to ensure that the original concerns from previous or current admissions had been fully resolved. This was particularly significant from the fourth admission when the out of hours GP referred Child N with a suggested safeguarding concern. Although this was considered initially on that admission, it was not fully resolved then and was never mentioned again in subsequent admissions until the final one when she was admitted in a critical state.

Were effective services provided?

4.2.3.3 Several different doctors oversaw Child N's care and both Paediatric and Orthopaedic specialists were involved. Some information such as the fact that only parents observed the apnoea episodes and that medical staff observed Child N's eye flickering were not fully considered when decisions on diagnosis and to discharge were being made. The possibility of an intra-cranial haemorrhage was mentioned on 13th March but not followed up as a possible indicator of non-accidental injury. Hip dislocation was seen as a high possibility for Child N's pain and floppy limbs but pain is not a marker of this condition and this should have been considered as a counter-indicator of medical cause as the explanation. Child N's Mother's suggestion that her own childhood DDH was a possible explanation was too readily accepted and not fully researched.

4.2.3.4 The information gathered was in relation to a possible medical cause. There is no evidence that any attempt was made to gather information to assess and question the behaviour of her parents – in relation to Father, in particular, as being the one who saw the apnoea which no one else apparently observed throughout a three day hospital admission.

4.2.3.5 The mind-set that there was a medical cause for Child N's symptoms was a major obstacle to consideration of other differential diagnosis; it also meant that medical and nursing staff were not sufficiently attuned to querying what the parents said; it was accepted at face value that only they observed the apnoea episodes. Research has shown that previous "sentinel injuries":

"…are common in infants with subsequently identified severe physical abuse and rare in infants evaluated for abuse and found to not be abused." ***Nugent et al 2013*.**

This refers to visible precursors or events which precede children receiving severe injuries; in Child N's case the unidentified cause of her painful leg and the two apnoea presentations in rapid succession, particularly when there was additional evidence of a neurological issue (eye flickering observed), are likely to have been sentinel events / injuries which, if they had been identified, may have resulted in earlier intervention to prevent further injury to her.

"Failure to recognize and take action when relatively minor, suspicious injuries occur may have devastating consequences for the infant and family." ***Paediatrics Nugent et al 2013***

4.2.3.6 There is some evidence that the parents were demonstrating they had some knowledge of the symptoms which they described and perhaps this might have been seen as unusual; this was the first child either of them had cared for and, although Mother had had some education in Biology, Father had not. When they were shown how to give life support to Child N if apnoea should recur, no one questioned how or when they had previously had this training – as they stated was the case. This significant level of medical "awareness" was not questioned or considered in relation to the high number of hospital admissions for Child N and these may have been indicative of the parents "fabricating" symptoms. However, it is not possible from the information available, and without a specific specialist assessment of the parents, to conclude that this was the case.

5. Child N's Experience

5.1 The indications are that for the first two weeks or so, Child N's parents were coping well with her care. Her Mother was initially breast-feeding her but this does not seem to have continued and by the end of March there is no further reference to this. The Midwives who visited were appropriately supportive and checked on the baby as well the parents' well-being and mental health. Child N's experience seemed to be good with loving parents who were connecting well with her and providing good physical care.

5.2 However from early March 2014, it appears that Child N's Mother's mental health had deteriorated and she was reporting feelings of depression. Evidence has emerged from the Police investigation following Child N sustaining the serious injuries, that her Father's handling of her became very rough and inappropriate; this was seen on a video made by her parents. By 6th March, it is now clear that injury had been caused to Child N and that she was in pain. Child N's experience from then until the hospital admission on 20th March seems to have been more concerning, though even on 18th March, when seen by the health visitor for a developmental check, Child N seemed to be alright in her Mother's care.

5.3 The expert clinical specialist who reviewed all the X-Rays and scans is of the opinion that the head imaging pictures were "consistent with a recent forceful acceleration/deceleration injury (shaking) around the time of (Child N's) clinical deterioration" on 20th March. There were also older rib fractures identified which were "consistent with forceful circumferential squeezing to the chest that occurred several weeks before the acute change." It was also stated that "the wrist injury is recent no more that than 10 days old at the time the skeletal survey was taken 8 days after presentation and is due to a forceful over extension injury. The *tibial metaphyseal* fracture is due to a forceful grab and yank type injury. The patterns of injury is that of non-accidental injury on several occasions by different mechanisms all involving force well beyond normal handling". It was the expert's opinion also that he would expect the perpetrator(s) to recognise that they had applied excessive force and that their actions had hurt (Child N) even if they did not realise they had fractured a bone.

5.4 It appears therefore that Child N would have been in considerable pain but also frightened and intimidated by this rough and inappropriate handling.

5.5 Child N has settled well with Foster Carers and she is making some progress. Her parents are still having regular contact with her; they allege that her injuries were caused by hospital staff. Police have been involved with a full investigation into these allegations, expert opinion has also been sought and it has been concluded that the injuries could not have been inflicted by hospital staff.

5.6 It appears that Child N has very limited sight as a result of her injuries and has overall developmental delay. Her sleep at night is erratic and she wakes most nights distressed, crying and screaming in the early hours of the morning. Child N does seem to gain some pleasure from touch and from food but it is clear that she will not now reach original potential.

6. THEMATIC ANALYSIS

This section addresses and suggests possible reasons for actions taken or not taken at the time.

6.1 What factors contributed to practice decisions at the time? Pre Birth?

6.1.1 It is clear that none of the agencies directly involved held all the information which would have been relevant to considering whether Child N's Mother and Father would have difficulties in parenting. However, neither the Midwife nor the Health Visitor sought to check out what the Mental Health Services knew about the parents; even though their mental health was seen as a vulnerability, it was not believed to raise a serious enough concern about their ability to parent because they presented in a positive way. The SG2 (Safeguarding Form 2) form was completed to alert colleagues in Health to this vulnerability. The parents only presented part of their history and they gave a positive impression through their preparation and avowed commitment to the baby which they said resulted from a planned pregnancy.

6.1.2 Although a plan to refer them to the Children's Centre was made this was not carried through. This seemed to have been an oversight – likely because all seemed to be well – Mother said she was not depressed – and because the parents were not apparently keen to pursue this either. To the health professionals, this did not seem to be a high priority case with major concerns and the parents sought to present this positive image. Indeed it seems likely that they were genuinely happy and looking forward to having the baby to care for.

6.2 What factors contributed to practice decisions at the time? Post Birth?

6.2.1 For the most part, Child N appeared to be having good and positive care from her parents during the first few weeks. They were proactive in seeking support, saw the Health Visitor and Child N had her first developmental check. All seemed well though Mother told the GP she was feeling down and she was prescribed antidepressants.

6.2.2 The possible opportunities to see beneath this arose when Child N was admitted to hospital – particularly the admissions in March. The first one prompted by the out of hours GP who referred Child N to hospital when she had a painful, floppy limb; he clearly made a good decision to make this referral; he wondered about a fracture and also included in his notes Mother's suggestion that the symptoms could be related to her congenital hip dislocation. At the hospital, both possibilities were considered but the medical causation was seen as more likely and was pursued. This rested on the fact that there was no clear sign of injury and the X-Rays were not seen to show fractures.

6.2.3 On the next admission it appears that non-accidental injury was not considered. The outcome of the previous admission led there to be a fixed mind-set that Child N's problems had a physical cause.

6.2.4 It is likely that a number of case specific and systemic factors contributed to a failure to consider non-accidental injury at this admission and with this presentation:

- Once again, Child N had no bruising or and other physical signs of injury.
- There were no obvious concerns in relation to the behaviour and responses of her parents, who seemed to be appropriately concerned and involved.
- As already discussed, information about the possible additional vulnerabilities for Mother and Father was not available to the Paediatric Team.
- Hospital systems – medical rota arrangements, paper and electronic records - did not facilitate the development of a clear picture of Child N's multiple admissions.
- Previous possible non-accidental injury concerns (in relation to the painful leg) had been forgotten and lost.

6.2.5 The parents' positive and concerned behaviour and presentation led the medical staff to believe there must be a physical cause and to adopt that optimistic view. There was insufficient critical analysis or challenge to ensure that the differential diagnosis of abuse was maintained as a possible element of, if not the main explanation, for Child N's symptoms and pain.

6.2.6 The professionals who were involved with Child N and her family had all received relevant safeguarding training; they should have had the knowledge to avoid ruling out completely the idea of a differential diagnosis of non-accidental injury. Within the hospital, additional specialist safeguarding advice could have been sought but there is no evidence that it was. The lack of clarity about and availability of the Paediatric Liaison Nurse was another missing opportunity for Child N's case to be reviewed and considered holistically.

6.2.7 During the review, there was some concern about the behaviour of Child N's parents in particularly in relation to their contact with health services. We considered whether there may be an element of fabricated illness activity driving the parents' behaviour. Child N had several admissions to hospital during her first few weeks. Both her parents seem to have had an unusually high knowledge of some health issues and appeared to observe symptoms such as apnoea which were not seen by others. Child N was physically abused but it is not possible to understand fully her parents' behaviours or whether her "illness" provided them with inappropriate "gratification". Although this issue was considered, no conclusions have been reached as this would require a psychological assessment of the parents to identify their concerns and behaviours.

6.2.8 It is likely that after Child N was born, her parents coped with caring for her. However, particularly for Father, it was stressful to care for such a highly dependent infant; his own experience as a child of being neglected and physically abused for many years, is likely to have impaired his own capacity to respond appropriately to such a young infant with tender, sensitive care and handling.

7. Findings

7.1 There should have been greater consideration of safeguarding as an alternative explanation for the symptoms the baby had during her hospital admissions. There is a need to manage a balanced judgement between purely (or mainly) medical causes and other social and parental factors particularly in young babies who are immobile and entirely dependent on their parents.

7.2 This case demonstrated that non-accidental injury can be difficult to recognise. All practitioners working in this field need to be aware that significant injuries such as fractures can occur without bruising or other visible signs, and that fractures may even be "missed" on X-Rays. There are particular difficulties if the right level of experienced Paediatric Radiologist is not available.

7.3 The first requirement for recognition of non-accidental injury is a high level of awareness of the possibility. In this case there were two occasions where a very vulnerable young and immobile infant presented with symptoms that were not adequately explained at the time. In retrospect, it is very likely that both these presentations were directly linked to abuse, but any suspicion of non-accidental injury was lost at an early stage.

"Many children who have suffered some form of abuse present to the accident and emergency department or clinic; however, none of the screening markers currently used to identify children who should be assessed further for possible abuse or neglect (e.g., repeated presentation, age, injury type) have been found to be sufficiently accurate. Therefore, clinicians should maintain a high level of suspicion for abuse in injured children who present to the A&E department or clinic with or without these specific characteristics of abuse." ***BMJ Best Practice.***
http://bestpractice.bmj.com/best-practice/monograph/846/diagnosis/step-by-step.html

7.4 The working hypothesis should be that abuse should be actively investigated with consideration given to additional investigation or further opinions, proportionate to the circumstances of the case. In this case, Child N was a completely dependent immobile infant with an unexplained injury. Abuse should not be seen as something additional to consider and to identify after all possible medical causation has been explored. In this case, a lack of physical injuries, initial normal X-Ray reports, and no apparent concerns about parental interaction, may have allowed a judgement (not made or recorded explicitly) that abuse had been excluded.

Practice guidance indicates that safeguarding concerns must be resolved before a child is discharged from hospital. Keeping an open mind and putting additional safeguarding measures in place are essential. In Child N's case, non-accidental injury had not been excluded as an explanation for her presentations to hospital.

7.5 The parents' apparently appropriate and concerned behaviour was insufficiently tested when Child N presented with unexplained symptoms. The parents sought to provide explanations from their own medical history; these were pursued without sufficient focus being kept on the possibility of non-accidental injury or abuse being present. This was partly understandable given the lack of identified clear visible physical evidence of abuse. However, the physical evidence which existed at her penultimate admission was not identified until her admission to Hospital B when Specialist Imaging was possible.

7.6 There were indications of possible neurological trauma. Inflicted brain injury such as a shaking episode can present with apnoea. Child N's presentation, with irritability followed by reduced responsiveness, should have suggested a possible neurological cause, including a shaking injury. In addition, a possible brief seizure (staring to the left with eye flickering) was noted soon after admission, but this does not seem to have been taken in to account when causes for Child N's illness were considered.

7.7 The absence of a Paediatric Radiologist in the hospital may have contributed to the failure to identify rib fractures on X-Rays taken at an earlier hospital admission. However, as safeguarding concerns were not identified or seen to be justified by the clinicians, the need for such detailed and specialist examination was not identified. If these fractures had been discerned from the X-Rays, it is possible that the subsequent serious injuries which occurred could have been prevented.

7.8 The X-Ray films were also available to view by the clinicians caring for Child N on the ward. As discussed above, possible signs of a fracture during Child N's admission with a painful leg were very subtle and likely to be missed by non-specialists. There is no evidence that any Paediatrician reviewed the Chest X-Ray during Child N's penultimate admission. This was a failure of usual expected practice, where there was the potential that the severe consequences for Child N might have been avoided. This has been recognised and acknowledged by the paediatric staff.

7.9 The Paediatricians would normally expect to review all films available on the ward. They consider that on this occasion, they relied on the fact that this film had already been reported by a Radiologist, whom they saw as having more expertise in this area. Having looked again at the chest X-Ray from Child N's final admission, they consider that all of the Consultants would most likely have identified the rib fractures on this film. This opinion is of course with the knowledge of Child N's actual injuries; rib fractures may be hard to recognise and "missed" fractures are an occasional occurrence in most hospitals.

7.10 Systemic factors made it harder to recognise possible risk in this case, hospital systems did not allow, through staffing or records, a single clear overview of the case particularly as it evolved rapidly over a short period of 10-12 days before Child N's final admission. Current approaches in Universal Services do not build a full picture of possible vulnerabilities for parents, and in this case even the limited information already available was not shared with the Paediatric Team. Better coordination and collation of information about each hospital visit could have ensured a better overview of events and the baby's experience which included unexplained severe pain.

7.11 Better read across of records and exchange of information about Mother's and Father's mental health problems between the Midwife, the Health Visitor, the GP team and the hospital would have provided a much more comprehensive and accurate assessment of the parents. The GP record also contained information about Father's childhood abuse. Consultation outside the immediate health professionals "team" with Mental Health Services and Children's Social Care would have provided a broader perspective to consider causes and explanation. The MASH was not contacted at any point to see whether there was any helpful information which could have been provided. Parents with mental health difficulties are more likely to need additional support to parent as various research studies have identified including Brandon's biennial studies of SCRs. In this case, however, the parents were cooperative, apparently strongly committed to the baby, and sought out advice and help.

7.12 Although there is access for clinicians to safeguarding advice within the hospital, there is no routine arrangement in place for the hospital teams to access multi-agency discussion of cases of concern. This is available and effective in some areas nationally through linking a Social Worker to local hospital services; this provision ensures that cases of concerns are considered more widely and that, in particular, the local Authority's records are checked.

8. CONCLUSIONS

8.1 Child N was a very vulnerable young child who was totally dependent on her parents for her care and safety. Both parents had troubled childhoods especially Father who was abused and neglected but who remained in the care of his parents. Both her parents have mental health problems and have sought treatment for these.

Babies are almost entirely dependent on their immediate caregivers. A parent's capacity to respond appropriately to the motions and needs of their babies has a profound impact. Becoming a new parent is a major transition; there are times when every parent feels under pressure and may struggle to cope with the stresses and responsibilities of their role. But, for very young parents, or parents facing additional challenges in their lives such as mental illness and domestic abuse, this can be a particularly difficult time.
NSPCC 2011 All Babies Count

8.2 It seems that the stress of parenting led to difficulties for them in caring safely for Child N. Unfortunately, in many respects and for several weeks they presented as appropriately caring and concerned parents who were managing. However, from early March, Child N was brought to hospital on two occasions with unexplained symptoms. On the last admission, she was in a critical condition having sustained significant injuries at home. Her life was saved but she still has been left with major disabilities and developmental difficulties from which she will never fully recover.

8.3 At the time of writing, the parents have declined the opportunity to contribute to this review. Their perspective would be a very important factor in helping us understand what occurred and it is to be hoped that they will reconsider whether they would like to contribute.

8.4 There was much positive practice in this case. The Midwife rightly identified the potential vulnerability of Child N's parents. She provided advice to them and informed other health professionals of the possible need for additional support when the baby was born. The Health Visitor and GPs responded appropriately when the parents sought advice about Child N's care.

8.5 It is possible that the difficulties which Child N's parents experienced in caring safely for her could have been predicted if the full information about them and their histories had been known. However, there were several positive indicators pre-and post-birth that they were managing and devoted to their baby. The parents themselves, particularly Father, withheld some key information which would have raised the level of concern and may have led to further information being sought from Mental Health Services and Children's Social Care.

8.6 Unfortunately in the last two to three weeks before the non-accidental injury which almost led to Child N's death, the likely "sentinel" presentations such as her painful leg and apnoea episodes were missed. The parents explanations were accepted and insufficient consideration of differential diagnosis on non-accidental injury in such a young baby was not kept in mind; the fact that only Child N's parents had seen the apnoea episodes even though medical staff saw nothing during her two admissions to hospital lasting several days was not questioned; the observations of unusual eye flickering seen by two staff was not fully explored.

9. Recommendations for LSCB to consider and action

9.1 NSCB to ask the Designated Doctor to ensure processes are in place within the Acute Hospital Trusts for specific clinician case accountability, clinical overview and follow up for individual children when non-accidental injury is a possible diagnosis.

9.2 NSCB to support the CCG and Designated Doctor to review and develop an audit process to test the effectiveness of clinical practice in the identification of non-accidental injury including consideration of differential diagnosis and to ensure that there is clarity about how concerns should be shared and referred.

9.3 NSCB to review how joint working can be improved between Health (the acute hospitals) the multi-professional MASH and Children's Social Care when non-accidental injury is suspected particularly in relation to children under 4 months old. Consideration should be given to whether there should be a direct regular multi-disciplinary contribution to the work of the Emergency and Paediatric Departments at Northamptonshire Hospitals. There is a particular need to consider the arrangements for consultation out of hours.

9.4 NSCB to ensure that the importance of all practitioners seeking, collecting and sharing all available information about family and parental history is fully appreciated – through its learning and development and case auditing activity.

9.5 NSCB to ensure - through its learning and development activities **-** that all practitioners are required to ensure Fathers, and their history, are fully included in their work with families.

10. Next steps - Progress Report / Learning

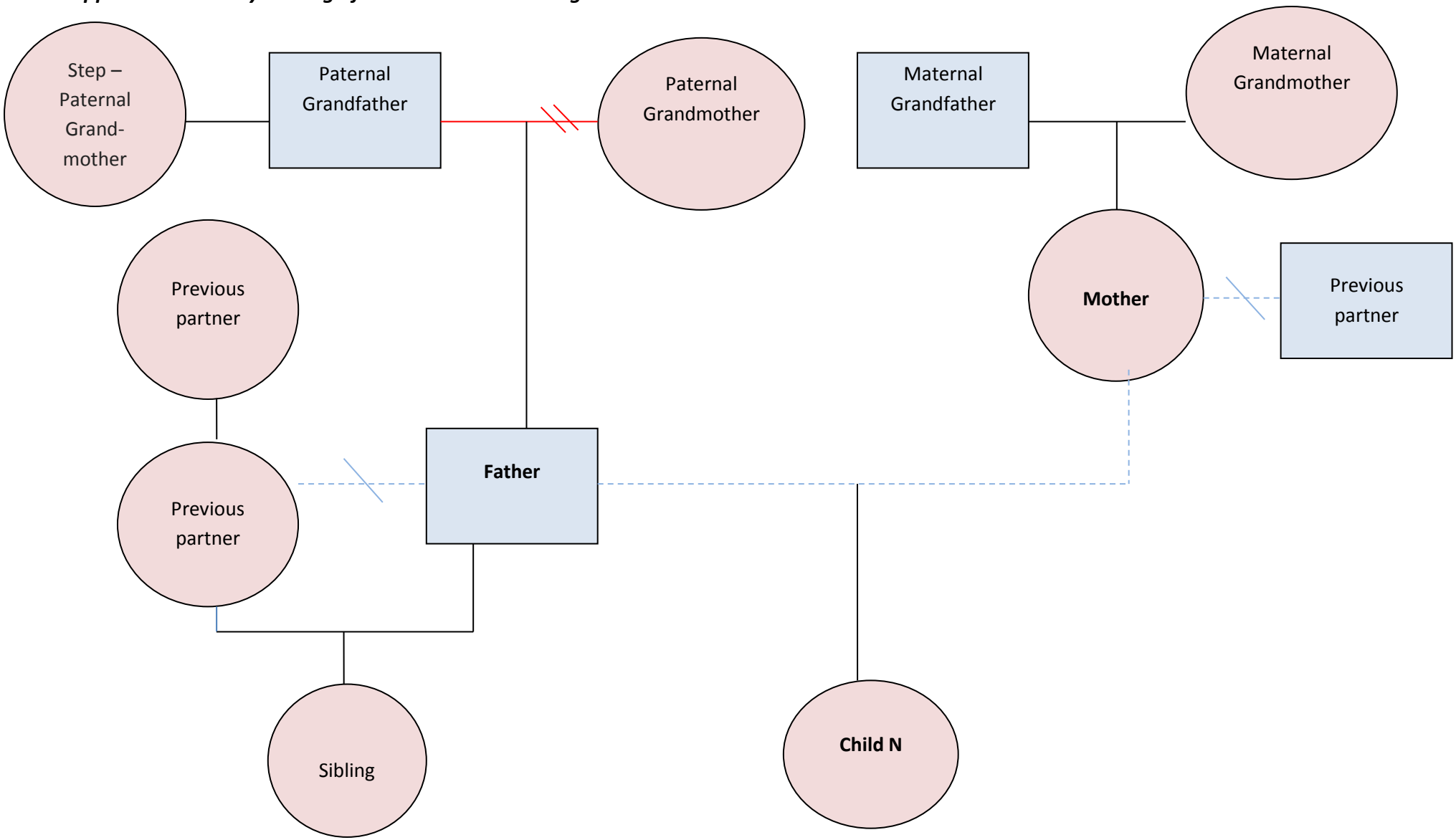
Since this review was established a number of measures have been put in place to respond to the learning from the case:

Health Professionals no longer complete SG2 Safeguarding Forms and are expected to complete a Common Assessment (CAF) if they believe parents are vulnerable and require additional support to parent effectively.

- A pilot project with Northamptonshire GPs is trialling a process to ensure that information about fathers is shared with professionals even when the father is registered with a different GP from the mother.

- Lack of identification of non-accidental injury – an external safeguarding review has been undertaken at the hospital and additional training and support provided to clinicians by an independent clinician.
- Lack of paediatric radiology access - The hospital has now obtained a limited amount of specialist paediatric radiology expertise, through a contractual arrangement with a larger paediatric centre. This is in the context of the continuing national shortage of paediatric radiologists.
- The role of the paediatric liaison service has been reviewed and changes implemented to ensure it reports on emergency admissions.
- Access to inter-agency consultation about cases of concern has been improved through the advice line at the MASH which has been in place since April/May 2014. If any professional wants to make a referral or speak to a senior practitioner; the number has been published in several newsletters from the Children's Services Improvement Board and the LSCB. In addition to the advice line, there is also a helpline if there is a question about a CAF.
- Further discussions supported by the Designated Doctor are continuing between the local authority and the acute hospital to consider how further improvements can be made to increase access to consultation including out of hours.
- There is a new Northamptonshire Safeguarding Children's Board protocol about (unexplained) bruising in young babies – the "Bruising/Marks in Non-Mobile Infants Policy and Toolkit".
- The NSCB undertook in 2014 a scoping exercise of six cases where pre-mobile babies had sustained non-accidental injuries – the findings of this review have identified some similar issues and there is an action plan in place to take forward the learning.
- Workshops for practitioners and managers and locally have been held to discuss the findings and to share the learning locally.
- The LSCB will continue to share the learning from this review in its regular workshops about the findings from all recent SCRs and in its interagency training.

Appendix A - Family and Significant others and Genogram



Appendix B - Scope and Full Terms of Reference

1. Introduction

1.1 Child N sustained a serious injury on 20th March 2014 which is thought to have resulted from physical abuse. She survived but it is likely that her development and physical health will be permanently impaired – though the degree of this impairment is not yet clear.

1.2 The Serious Case Review Panel made the recommendation to the Chair of the LSCB that, with reference to the requirements as set out in Chapter 4 of *Working Together to Safeguard Children* (2013)[1], the threshold was met to commission a Serious Case Review in respect of Child N.

1.3 The decision to undertake a serious case review was taken on (insert date).

2. Purpose and principles for the Review (SCR)

2.1 The purpose of the review is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations are expected 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.

2.2 The following principles – as set out in Working Together 2013 - should be applied by the LSCB and its partner organisations to all reviews:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- 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 should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to reviews[2]. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring the child is at the centre of the process[23]
- Final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency. The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must be described in LSCB annual reports and will inform inspections; and
- Improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

[1] Working Together 2013 – Dept. for Education.

[2]British Association for the Study and Prevention of Child Abuse and Neglect in Family involvement in case reviews, BASPCAN, further information on involving families in reviews.

2.3 SCRs and other case reviews should be conducted in a way which:

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

3. Scope and methodology for this review

3.1 The following principles will govern the review and the role and responsibility of the Lead Reviewer:

- Fairness
- Impartiality
- Thoroughness
- Accountability
- Transparency
- Focus on the Child's experience

3.2 The SCR will be carried out within a Root Cause Analysis Framework. The focus of this systems based approach is on what happened to Child N's interaction with the systems around her. A key part of the approach is to understand how things were perceived and the rationale for decisions, actions or inactions ***at the time.*** It will be carried out by and experienced, independent Lead Reviewer who has a good understanding of interagency safeguarding including health and children's social care.

3.3 The process will include:

- Requests to each agency for information and briefing of IMR authors
- SCR Panel for completion of scoping and Terms of Reference for the review
- Initial briefing for managers and practitioners on the case
- Focused interviews with staff involved by IMR authors
- SCR Panel to receive IMRs and discuss initial findings
- Feedback workshop for managers and practitioners on the findings thus far
- First draft of Overview report by Lead Reviewer and mapping of findings within the Learning Summary
- SCR Panel to receive draft SCR report and to discuss
- Lead Reviewer to deliver final SCR for publication – December 2014
- Presentation to LSCB and discussion of action required on findings and areas for consideration, recommendations – January 2015
- Follow up learning workshop for managers and practitioners

3.4 The IMR interviews with managers and practitioners will explore:

- critical points in the case
- possible reasons for actions taken at the time
- the significance of these insights for current practice.

3.5 The critical points in the case that will be considered are:

1 What information, prior to and following Child N's birth, was known about the mental health of both her parents? Was this information effectively shared between agencies?

2 What early intervention services were provided to support the parents and protect the unborn child? Please give consideration to whether the Pre-Birth Assessment was timely and robust, and whether a Pre-Discharge Plan was required? Were issues of domestic violence appropriately explored during Mother's antenatal care?

3 A Safeguarding 2 (SG2) form was completed by the Midwife, was this document shared with other agencies? Why was a CAF not considered or completed and would this have alerted agencies of the need for early intervention provision?

4 In early March 2014 Child N was brought to the Emergency Department of Hospital A and was admitted with a painful right leg. No obvious fracture was identified and she was discharged two days later. Were the X-Rays taken at that time reviewed by a Paediatric Radiologist? Was a differential diagnosis considered? Why was a referral not made to Children's Social Care at that time?

5 Child N had six admissions to hospital over a period of 5 weeks from the time of her birth until she was admitted to hospital with life threatening injuries. Was there a delay/lack of completion of Paediatric Liaison Forms? Was the Health Visiting Service informed of Child N's admissions and if so what actions resulted? Was a chronology made of these admissions and were health professionals alert to the safeguarding concerns presented? What was the process for paediatric review of the case and was it consultant led?

6 The possible reasons for actions taken / not taken at the time

7 What factors might have contributed to practice decisions at the time?

8 What could have been improved?

9 Was there any consideration given to differential diagnosis and the possibility that Child N may have been subject to non-accidental injury or "Fabricated or Induced Illness"?

10 It is known that in the past Father had been subject to Child Protection plans and that he had fathered a child with a mother who was 15 years old when she gave birth. What information was known to agencies about Father's history and his parenting capabilities?

11 What level of safeguarding children training had professionals involved with Child N and her parents undertaken, and how did that training inform decisions taken at the time?

12 The significance of these insights for current practice.

13 If the same event occurred now – what factors would influence the response?

14 What is working well now and what still needs to be improved?

IMR authors should consider and research whether there has been any change initiated following the events which occurred in this case and / or whether further change or improvements are required.

3.6 Focus on the Child's Experience

All those involved in undertaking these enquiries will take full cognizance of the child's experience: Child N's experience as a baby living with her parents, her numerous hospital admissions and the consequences of the injuries she sustained.

4. Analysis and interpretation of the Information gathered.

The methodology agreed for this review will include conducting conversations with the practitioners and clinicians involved, and holding a multi-agency briefing at the start and near the end of the process, in order to identify learning and encourage reflection on their involvement; to examine the actions and decisions taken; and to understand the context.

An adapted version of the "fishbone" diagram – a tool used within root cause analysis - will provide the framework for taking a whole system approach.

The aim of using this framework is to gain an understanding of how the interaction between the various factors influenced the way practitioners responded to Child N and her family. It seeks to look at cause and effect and to extract the lessons from considering why and how things occurred.

The appended diagram sets out the model framework for analysis which will be applied by the lead reviewer.

5. Scope of the Review and Timescale

5.1 The period under consideration for this Review will be from May 1st 2013 to 31st May 2014. Agencies will need to consider the period from 1 May 2013, when it is believed Mother became pregnant with Child N and up to and including 31 May 2014 when Child N began to recover from her injuries.

5.2 Where there is additional historical information relevant to the review going back beyond these dates (e.g. within the parents' own childhoods) agencies should provide a summary of their previous involvement within the Individual Management Review in the section Background. This should include a summary of early contact with the family relevant to the learning and the approach to multi-agency working.

Appendix C - Membership of the Northamptonshire LSCB Serious Case Review Panel

- Independent Panel Chair
- Independent Lead Reviewer (in attendance)
- East Midlands Ambulance Service, Head of Safeguarding
- Integrated Business Office, Safeguarding Project Officer
- Kettering General Hospital Trust, Director of Nursing & Quality
- Legal – Northamptonshire County Council, Principal Lawyer
- Nene & Corby Clinical Commissioning Groups, Designated Doctor for Safeguarding
- Nene & Corby Clinical Commissioning Groups, Head of Nursing
- Northamptonshire Foundation Health Trust , Patient Safety Manager
- Northamptonshire Police, Head of the Protecting Vulnerable Persons Department
- Safeguarding and Quality Assurance Service - Northamptonshire County Council, Head of Safeguarding
- Serious Case Review Sub Group Representative

Appendix D - List of References

Brandon M, Pippa Belderson, Catherine Warren, David Howe, Ruth Gardner, Jane Dodsworth and Jane Black - Analysing Child Deaths and Serious Injury Through Abuse and Neglect: What can we Learn? A Biennial Analysis of Serious Case Reviews 2003-2005

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