**TAMESIDE SAFEGUARDING CHILDREN BOARD/PARTNERSHIP**

**Serious Case Review**

**CHILD V**

**Amanda Clarke**

**03 February 2020**

**INTRODUCTION**

1. This serious case review (SCR) was commissioned by the Independent Chair of Tameside Safeguarding Children Board 4th June 2018; in agreement with the recommendation of the TSCB Serious and Significant Case Panel that the circumstances surrounding the death of, or significant injury to a child met the criteria for a serious case review.
2. The subject of the review is Child V. Normally in overview reports a pseudonym is used to ensure focus on an individual child albeit using a different name. Applying a different name is to protect the child’s and family’s identity. However, the family of Child V prefer the name Child V to be used and this request has been respected.
3. Child V was seriously harmed in 2018, aged under three months. Circumstances leading to the significant incident are outlined below in the circumstances and history section of the report.

**THE SERIOUS CASE REVIEW PROCESS**

1. Legislative frameworks and guidance[[1]](#footnote-1) in place at the time of the incident were considered when the TSCB made the decision to undertake a serious case review. It was suspected at the time that Child V had suffered serious harm as a result of abuse or neglect. Further detail regarding the criteria specific to the case of Child V is included at Appendix A.
2. The methodology used for this review was based on *the Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012).* This is a formal process that allows practitioners to reflect on cases in an informed and supportive way. Documenting the full history of the child and family is not the primary purpose of the review. Instead it is an effective learning tool for local safeguarding children boards and partnerships to use where it is more important to consider how agencies worked together. The detail of the analysis undertaken of the case is not the focus of the reports which centre on identification of learning themes and improving practice.
3. The opportunity to conduct serious case reviews in this, and other ways, is as a result of the change in statutory guidance following *The Munro Review of Child Protection: Final Report: A Child Centred System, May 2011.* Munro suggested that local safeguarding children boards should use any learning model which is consistent with the principles in the *Working Together to Safeguard Children Guidance: Learning and Improving, HM Government 2015* which was the guidance in place at the time the review was commissioned.
4. However, because a review has been held, it does not mean that practice has been wrong and it may be concluded that there is no need for change in either operational policy or practice. The role of local safeguarding children boards/ partnerships is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the review can be used to inform systems and practice development. In so doing the board/partnership may identify additional learning issues or actions of strategic importance. These may be included in the final review report or in an action plan as appropriate.
5. Following notification of the circumstances of the injury caused to Child V, and agreement by the chair of the TSCB to undertake a SCR, a review panel (to be known as the Panel) was established. The Panel included representation from relevant organisations within Health Services, Children’s Social Care and the Police.
6. Amanda Clarke, an independent chair and reviewer from Derbyshire (the Reviewer) was commissioned to chair the Panel and to lead the review. Amanda Clarke has no professional connection to Tameside or the organisations and professionals involved in the case.
7. The Panel identified the review timeframe as 24.08.16 to 16.05.18. The start date reflects when the pregnancy became known to services and the end of the timeframe allows early responses to the significant incident to be considered.
8. The Panel had agreed this was an appropriate period to review services relating to Child V and her family, on the understanding that historical information would be taken into account, shared where relevant, and provide context.
9. Terms of reference for the review were developed by the Panel prior to the Reviewer being commissioned and are included at Appendix B.
10. All relevant agencies reviewed their records and provided timelines of significant events and analysis of their involvement for the identified review timeframe. These were considered by the Panel and provided opportunity for Panel members to raise questions and clarify understanding of the circumstances of the case and of the separate services provided. The agency timelines were merged and used to produce an interagency timeline. This was carefully analysed by the Reviewer with the Panel and informed of the areas of interest that required further exploration and consideration. The process also allowed for the identification of the key practitioners to be invited to attend a learning event in order to understand the detail of the single and interagency frontline practice in this case.
11. The practitioners’ learning event was held in September 2019 after a delay due to criminal proceedings relating to the case. The learning event was attended by eight professionals. Most practitioners attending had had direct involvement with Child V or her family. Those attending who had not worked directly with Child V were able to provide the position and perspective of the service delivered to the family.
12. The Reviewer facilitated the learning event[[2]](#footnote-2) assisted by the business manager of TSCB. Notes were taken during the event.
13. Following the learning event, the Reviewer collated and analysed the learning to date for discussion with the Panel. Practice issues and themes originally identified by the Panel were re-examined in the light of the findings of the review. In reviewing the findings, the Panel considered what could be done differently to further improve future practice. A draft report was provided to the Panel in November 2019, in advance of the Panel meeting on 25 November 2019. Further enquiries were made as necessary after the draft report had been considered and the report was updated.
14. The report contains learning themes and recommendations for the Tameside Safeguarding Children Partnership to consider in developing an action plan to ensure learning from the case is embedded in future practice.

**Circumstances and history resulting in the review**

1. Child V was the first and only child of her mother (to be known as Mother throughout this review report). Information was presented to the review that father of Child V (to be known as Father) is thought to have two other children living elsewhere in the country but with whom he has never had contact. Mother and Father had been a couple for approximately 5 years prior to the significant incident resulting in the injury to Child V. At the time of the incident they were living together as a family in Tameside. Mother was local to the area but Father had moved there from the south of the country after they had met online before commencing the relationship.
2. An unconnected allegation of non- recent sexual abuse was made against Father in late 2016. The circumstances related to Father when he had been living in the south of the country as a young adult around 2009. The victim was aged 11 years when the alleged incident took place and had known Father through family connections.
3. The complaint was initially investigated and managed by Devon and Cornwall Police. Due to circumstances to be explored later no contact took place between Devon and Cornwall Police and Greater Manchester Police, which was the police area where Father was living, until early 2018.
4. Mother became pregnant with Child V in the summer of 2017. She and Father both attended a first appointment together with the community midwife and Mother continued to engage with routine health appointments relating to the pregnancy until the birth in spring 2018. Father was noted in records as present at some but not all appointments.
5. There was no children’s social care involvement with Mother and Father during the pregnancy. The pregnancy was considered normal with no concerns highlighted.
6. After Child V was born midwifery staff at the hospital noted that Mother and Father appeared un- prepared with inadequate clothing packed for the new-born Child V to be used in and on leaving the hospital. A supply of baby clothes was provided by the ward.
7. Once discharged from hospital postnatal home visits commenced by the midwifery team. The health visitor also saw the family and Child V was assessed as a normal, healthy baby. Mother and Father appeared to be coping as new parents and therefore a universal service[[3]](#footnote-3) was considered as suitable for the family, with the next health visitor appointment due when Child V was six to eight weeks old.
8. When Child V was two weeks old, after a request from Devon and Cornwall Police an officer from Greater Manchester Police attended the family home. Father was present with Mother and Child V. An interview was arranged regarding the non-recent incident which had been reported in Devon and Cornwall. The voluntary interview took place the following week during which Father denied the allegation. Feedback was provided by the Greater Manchester officer to the Devon and Cornwall officer who had management and responsibility for the case.
9. Information regarding the non-recent sexual abuse allegation was not shared by either police service with any external agency.
10. When Child V was seven weeks old the health visitor conducted what was to be her last home visit, prior to the injury being caused. Mother and Father were both present. It was explained that Mother had needed to return to work and that Father was caring for the baby when Mother was out. Child V was observed as alert and active, clean and appropriately dressed. There were no obvious concerns noted during the visit and a next contact was arranged for Child V nine to twelve months development check.
11. Later, on the same day of the health visitor’s attendance, Father was caring for Child V whilst Mother was at work. An ambulance was called by Father who reported Child V had become unwell. Investigations at hospital revealed that Child V had suffered a significant brain trauma believed caused non accidentally by shaking.
12. Police enquiries resulted in Father being arrested and subsequently charged with an offence relating to the cause of the injury to Child V. Father pleaded guilty at court in the summer of 2019 and was sent to prison.
13. In the separate investigation Father was not charged regarding the non- recent sexual abuse allegation in Devon and Cornwall.
14. Child V has life changing injuries but has been described by her carers as a happy, sociable, strong baby.

**Family involvement**

1. Involvement of significant family members in a review process is important to gain an understanding of the family’s experiences of the services offered to them and their child. Specifically, in this case, Mother and Father were asked to provide feedback relating to services provided during the review timeframe to Child V and to the family as a whole.
2. Father was invited to meet with the Reviewer but declined.
3. Mother met with the Reviewer in September 2019. A summary of the views of Mother is given below. Other comments are included in the analysis section of the report where relevant.
4. The valuable insight into Child V and the family’s experiences from Mother’s perspective and memory was shared with the Panel at draft report stage. Account was taken of the views and opinions when finalising the report and formulating recommendations and the Reviewer is grateful for Mother’s contribution.
5. Mother said she first encountered Father online. They were both interested in online gaming which is how they met. Father moved to the Tameside area around 2013 and Mother described their relationship as “mostly great”. Father told her he had two children from his early adulthood but that he knew little about them and didn’t have contact.
6. Mother said that Child V was a “planned for baby” and they were both happy when Mother became pregnant.
7. When asked about possible domestic abuse in the relationship Mother described one argument when Father threw a plate at the wall. This was the “only time an argument became serious” in her opinion. She denied ever considering herself as having been a victim of any domestic abuse from Father. There were no recorded domestic abuse incidents relating to the couple within the Greater Manchester Police area.
8. Mother had limited feedback to share about individual professionals who had had contact with her. She described people who supported her as “nice”. She remembered seeing different professionals through the pregnancy and birth and said that if possible she preferred being able to see the same person to build trust.
9. When asked specifically about advice provided, she remembered professionals speaking about safe sleep for babies but she did not recall being spoken to about safe handling of babies or the dangers of shaking. Mother was very clear she knew shaking a baby was wrong and said she “thought everyone would know that as its common sense.”
10. Mother recalled seeing the health visitor on the day that Child V was injured. She believed the health visitor was satisfied with the care of Child V as she thought the family were being “signed off for a while”.
11. Mother explained her return to work was due to financial pressures. She said she thought Father was happy to look after Child V and that “he seemed a good dad” before the incident.
12. Mother was aware of the non-recent sexual abuse allegation against Father. She said she had Child V in her arms when the police attended to see him at their home. After being interviewed Father told Mother about the alleged circumstances and that he “denied everything”.
13. Mother said after Child V was injured that she did not believe Father was responsible but this opinion changed over a period of time when more information came to her attention.

**ANALYSIS:**

**Practice & Organisational Learning Identified**

1. Child V and her immediate family had received services from different agencies during the timeframe of the review. Information from all sources including from agency records, the practitioners’ learning event and contributions from Mother have provided an opportunity for wider learning to emerge about the ways in which services work together and how families are supported. The following, in no order of priority, is an analysis of the themes identified.

**Preventing abusive head trauma**

1. Whilst the full facts are not clear of what happened surrounding the significant incident to Child V, it is known that the injury sustained was an abusive head trauma. Often referred to as ‘shaken baby syndrome’ abusive head trauma can cause catastrophic injuries or death. When a baby is shaken, thrown, swung or hit against a hard surface the result, as in the case of Child V, is abusive head trauma. Described in court as “a momentary lack of control” by Father this, and other similar cases, demonstrates the devastating outcome for children who are victims of this type of abuse.
2. The condition occurs most commonly in children younger than two years of age with an estimated prevalence of 1: 3000 in babies younger than six months[[4]](#footnote-4). The persistent incidence of abusive head trauma in the UK is 20 to 24 per 100,000 children[[5]](#footnote-5).
3. Many local safeguarding children board areas (now known as partnerships) have introduced education programmes for parents and carers of babies, and for professionals supporting them to raise awareness about appropriate responses to crying babies, which is when abusive head trauma can often occur. The evidence based, multi-agency programmes, for example ICON[[6]](#footnote-6) which has been implemented widely across the country, reinforce simple messages to support parents and carers at stressful times with their babies in order that abusive head trauma may be prevented.
4. Currently there is no education programme as described above being used consistently with parents and carers across Tameside. This was evidenced through examination of records as part of the review, by discussion with practitioners attending the review’s learning event and by the Mother of Child V. Neither Mother nor Father received key messages and advice relating to responding to a crying baby and that a baby must never be shaken.
5. Research suggests persistent crying in babies as being a potential trigger for some parents and carers to lose control and shake a baby. Research also shows that around 70% of babies who are shaken are shaken by men[[7]](#footnote-7), as occurred in this case. Therefore, any education and prevention programme must include male parents and carers with the best opportunities of how and when to reach men explored.

51. The Reviewer was told currently in Tameside conversations are ongoing regarding postnatal records being amended to include a discussion around advice relating to shaking babies. Other opportunities and methods of providing support to parents and carers about shaking both in the antenatal and postnatal period are being explored.

**Recommendation 1**

**The Tameside Safeguarding Children Partnership must require assurance from Public Health and relevant partners that a programme of awareness and prevention relating to abusive head trauma is developed, agreed and implemented for use across the partnership area with all parents and carers.**

**Recommendation 2**

**The Tameside Safeguarding Children Partnership Quality/Assurance sub group should require its members to provide evidence that the abusive head trauma awareness and prevention programme is being consistently provided as agreed by health partners and key messages are being reaffirmed by professionals across the partnership to ensure babies and children are protected from abusive head trauma at every opportunity.**

**Opportunities to consider safeguarding in health appointments pre and post birth.**

52. Mother and Father engaged with health professionals throughout the pregnancy and after the birth of Child V. There was no delay in presentation; both parents attended the initial booking appointment nine weeks into the pregnancy.

53. Analysis of records and discussions at the practitioners’ learning event indicated some enquiries were made with the couple regarding previous social care history. Mother accurately declared no experience or involvement with social care. Father had an extensive social care history from his childhood but this was not volunteered or requested. The history related to his earlier life in other areas of the country. Mother did disclose Father had two other children, as discussed above, but no further enquiries ensued. There was no reason identified at this point for the Specialist Enhanced Midwifery Team to become involved, which is a service for families who are considered vulnerable.

54. There is no evidence in records made before the birth of Child V that Father’s history was revisited. Professionals were not presented with a substantial reason to enquire further into his past and therefore this did not occur as routine. There were no concerns raised about the couple during the pregnancy and no information had been shared with health professionals about the ongoing non-recent sexual abuse enquiry in Devon and Cornwall. This will be explored later.

55. Within ten days of the birth the health visitor conducted her initial visit. The Reviewer was told there is an expectation locally that women will see a health visitor in the antenatal period. In reality, due to available resources this does not always happen for families under the universal service offer where there are no known concerns. This was the position for the family of Child V. The Reviewer was assured that visits are prioritised regarding the identified level of need.

56. Notes from the first health visitor contact were comprehensive. Both parents were present with Child V. It is positive that the health visitor explored Father’s contact with his other children and his own family history from a health perspective. The health visitor was able to obtain some pertinent information but due to the family being assessed as coping well there was no requirement for the information gathered to be scrutinised further or shared.

57. What became known after the significant incident for Child V, was a large chronology of involvement existed for Father throughout his childhood with different local authorities. This was in addition to the allegation of non-recent sexual abuse being investigated throughout the pregnancy and birth period, albeit agencies other than the police were unaware of the sexual abuse matter.

58. It is questionable whether knowledge of Father’s own history would have made a difference to how health professionals viewed him, his parenting capacity or the family as a whole. Mother and Father were observed as normal caring parents and no substantial concerns were raised about them pre or post birth, or before Child V became injured. However, findings in a number of other reviews nationally about hidden men and new men in families generally, reiterate the importance of professionals taking the opportunity to gather information which may help to identify risk.

59. Health professionals in particular must remain professionally curious and have the confidence to enquire into the history of parents, challenging where necessary if information is not being volunteered. Collating health history is important to ensure any hereditary or genetic issues can be identified but the gathering of family history may highlight other issues which are key to a baby’s development and the assessment of an individual’s parenting capacity. A wealth of research now exists highlighting strong association between adverse childhood experiences (ACEs) and poor health and social outcomes for families. The Reviewer was told ACEs are included in some local training programmes and an ‘Understanding ACEs’ information flyer is available. However, there is no consistent provision across the Partnership to raise awareness of ACEs.

60. Professionals may only act on information that is known or provided, which is reliant on parents and carers being open and honest about their own experiences. However, an unusual response to standard information gathering or refusal to disclose history may affirm other concerns which had not yet reached a point of being significant.

61. It is acknowledged health appointments are short requiring many tasks to be completed. However, it was demonstrated by the health visitor on her initial contact with Child V and family that it is possible to build rapport and obtain useful information alongside routine checks being undertaken.

**Recommendation 3**

 **The Tameside Safeguarding Children Partnership should explore opportunities locally for professionals to be more aware of the significance of adverse childhood experiences and the importance of proactive professional enquiry regarding family histories to ensure improved social outcomes for children and their families remain a priority.**

62. When Mother met with the Reviewer, she (Mother) said in her opinion domestic abuse had not been a factor in her relationship with Father.

63. In health appointments relating to pregnancy and post birth it is an expectation that domestic abuse will be explored with the mother[[8]](#footnote-8). Commonly known and recorded as the ‘routine enquiry’ this is an opportunity to enquire with a woman about her experience of domestic abuse both present and past. Should a response be received that domestic abuse is a concern then further safeguarding advice and/ or action must be taken to ensure risks to the unborn child/ new baby and the mother can be assessed.

64. The routine enquiry should take place when the partner of the mother is not present in order to provide an opportunity for the woman to speak openly. On the first two ante natal appointments Father accompanied Mother and the routine enquiry was not carried out. Health professionals attending the learning event explained it is sometimes possible in appointments to create an opportunity to speak to a woman alone even when she is accompanied. An example was given of asking the partner to collect a sample pot from reception, or a similar task. This did not happen for Mother’s first appointments.

65. Mother attended the next two appointments without Father but records show that no routine enquiry occurred. When discussed at the learning event it was apparent that it is a challenge to quickly identify in records that a routine enquiry has taken place. Expectant mothers retain their own records which, in an abusive relationship, would create a risk to the woman should a perpetrator look at her records and find domestic abuse had been discussed. As a consequence, reference to routine enquiry and domestic abuse is not always included, therefore different midwives becoming involved may not realise that the domestic abuse enquiry has not taken place.

66. The Reviewer was told records in hospital for pregnant women are easier to complete as these are separate to the handheld records of women, meaning partners would not be able to access the content. Unfortunately, community midwives do not have ready access to a woman’s hospital records and therefore cannot easily view that the routine enquiry has been undertaken, or that domestic abuse still needs to be explored.

67. There is no evidence that the routine enquiry was ever carried out with Mother during her pregnancy. As stated above there was no indication via Mother’s contribution to the review or through other information that domestic abuse was a concern within the family. However, the importance of domestic abuse being considered during pregnancy and after a baby is born should not be underestimated. Pregnancy can be a trigger for domestic abuse and existing abuse may worsen during pregnancy or after giving birth[[9]](#footnote-9). If standards are not followed for the routine enquiry to be completed when it is not obvious in records that the enquiry still needs to be done safeguarding concerns will not be identified resulting in possible continued risk to the mother and baby.

**Recommendation 4**

**The Tameside and Glossop Integrated Care NHS Foundation Trust should provide evidence and assurance that the Domestic Abuse in Pregnancy: Safe Routine Enquiry, Recording and Reporting Policy is being used appropriately, that enquiries relating to domestic abuse in pregnancy and new motherhood are undertaken and recorded in an accessible format, in order that mothers and babies can be safeguarded.**

68. The scrutiny applied to routine enquiry in this case resulted in discussion around the expected practice of recording who is present and accompanying women in appointments relating to antenatal and postnatal care. Recording who accompanied Mother at her appointments was mostly completed; she was normally with Father. However, it is good practice, which has been highlighted as necessary in several other reviews nationally, for whoever accompanies a Mother to be spoken to and their name and relationship recorded. This creates an opportunity for professionals to open conversations into wider history, family dynamics and should not be seen as an intrusion.

69. Prior to the discharge of Child V and Mother from hospital after the birth, records demonstrate a concern was noted regarding the preparation for Child V to be appropriately dressed for leaving. The parents had brought minimal baby clothing with them, especially for the time of year and expected temperatures. The nurse professional involved was proactive in finding donated clothing elsewhere on the ward which was provided to Mother for Child V. There were no other concerns at the time which necessitated further action and it is positive the observation regarding inadequate preparation was noted.

70. It was not obvious to the professionals attending the learning event and who had been involved with the family whether either parent had attended parenting classes in the ante natal period. Follow up enquiries have revealed that the couple did not attend either together or individually.

71. Information provided in the free sessions, known locally as NHS antenatal classes, would have included preparation for the birth and what to take to hospital. Dates of sessions are provided to new parents by the community midwife.

72. It is important that all new parents have access to clear, consistent advice about how best to prepare for a baby and parenting generally. Not all parents will have the opportunity or the desire to attend parenting classes but this should not preclude the need for them to be provided with relevant information. The Reviewer was told all new parents are given a booking pack containing information and leaflets but ultimately it is the parents’ decision as to what information to take on board. Families involved with the enhanced midwifery service, which Child V’s parents were not, are encouraged very robustly to engage in information sessions.

73. Due to the difference in recording systems as discussed above, the concerns about clothing for new-born Child V were not accessible in records to other community health professionals having routine post-natal contact with Child V and family after the hospital discharge. Professionals supporting the family in this early period of Child V’s life were therefore unaware of the need to be particularly curious about the family’s preparation at home for the appropriate care of Child V, albeit records for the immediate period after discharge indicate no further concerns observed.

74. Challenges relating to different recording systems and access to the information contained therein can be an ongoing problem particularly when handovers of a family’s care take place, for example when a new baby leaves hospital. Therefore, the importance of the need for both internal and external professional discussions about children and families to take place whenever possible should not be underestimated.

**Information sharing to enable wider safeguarding**

75. As detailed above an allegation of non- recent sexual abuse was reported to police prior to Mother becoming pregnant with Child V. The circumstances were not connected in any way to Father’s relationship with Mother, or to Child V or to the area where they lived. The timing of the offence was in 2009. The outcome of the investigation which concluded in 2018 was that Father was not charged with any sexual abuse related offences. Aspects of the investigation and how wider safeguarding was considered are explored below.

76. Records show the report was made and recorded as a crime in 2016 in the Devon and Cornwall Police area, which is several miles from Tameside. The case was not immediately dealt with but remained under review as a crime reported. It was monitored regularly by a supervisor which is routine practice and in two recorded reviews within the first ten months the supervisor added a note for ‘safeguarding around the suspect and relating to other children to be considered’. There is no evidence that this was completed, possibly due to delays in allocation and progression of the case. The suspect’s (Father’s) home circumstances or his contact with children were not considered further by Devon and Cornwall Police.

77. Just prior to the second review of the reported crime in Devon and Cornwall, highlighting consideration of wider safeguarding to be necessary, Mother and Father had attended the initial booking appointment for the pregnancy. By the time Mother was fourteen weeks pregnant an enquiry by Devon and Cornwall had located the general area (in Greater Manchester) where the suspect (Father) lived, but Devon and Cornwall Police were unaware that Father was about to become a parent himself. This was autumn 2017.

78. A request for support with the investigation, to trace Father, actually arrived in the local police area (Greater Manchester) in early 2018. However, an incorrect previous address for Father had been supplied causing other enquiries to be necessary resulting in further delay.

79. Mother and Father remained unaware of the allegation against Father until three weeks after Child V was born, when a local police detective attended their home. The officer recalled seeing the whole family together including Child V when the visit took place to arrange Father’s interview. The wider safeguarding issues of possible risk to the baby Child V because of the nature of the allegation against Father were not noted or shared with any other agencies.

80. The apparent delay in the initial management of the non- recent sexual abuse investigation has been explored. Reasons provided included resource issues and difficulties in contacting the victim (by then a young adult). Devon and Cornwall Police informed the Panel and Reviewer that lengthy police investigations are not uncommon but the delay would be considered excessive and the case should have been identified as requiring action and escalated.

81. Reviews were taking place as detailed above with wider safeguarding being noted by supervisors as to be actioned. However, the follow up to check actions were completed did not take place in subsequent reviews of the case. The current family circumstances (at the time) of Father were not known to Devon and Cornwall Police as he lived far away from that location. As a consequence, no further action was taken by that police area to assess and share any possible risks by Father to others, particularly children. No liaison was instigated by Devon and Cornwall Police with Greater Manchester Police that Father’s current circumstances and possible contact with children and other vulnerable people had not yet been explored.

82. When the Greater Manchester officer attended the home address it was clear that Father did have access to a child (Child V). However, the possible risks to Child V by a person who was being investigated for non-recent sexual abuse on a child were not recognised.

83. It is important that professionals are aware that an identified risk in one type or method of abuse, including the age and gender of victims should not lead to other risks being ignored.

84. It is positive that the officer did demonstrate some focus on the child by considering the state of the premises, which were described as untidy. This prompted an informal discussion with a colleague as to the risk of neglect and impact on the baby. An appropriate conclusion was drawn that there was no evidence of neglect and that no further action was required. However, the obvious risk of possible sexual abuse from Father, as stated above was not identified, discussed or shared.

85.When feedback was provided by Greater Manchester Police to the Devon and Cornwall Police about the interview and Father’s denials of the sexual abuse there was no reference by either officer to his current family circumstances which may have prompted a discussion about what further action might be necessary.

86. The opportunity for multi-agency information sharing about the allegation against Father and possible risk to Child V, was therefore not acted upon.

87. At Panel meetings and in the practitioners’ learning event there was discussion about what the result of a referral of this nature would be now. The Reviewer was told it is likely, due to the lack of service involvement with the parents previously that any action would be minimal. However, the local Multi Agency Safeguarding Hub (MASH) arrangements exist to ensure appropriate enquiries; information sharing and professional discussions take place on all concerns which are referred. Early help processes now exist and the opportunity for an early help assessment and associated support for Child V and family would have been considered.

88. In addition to support offered through the MASH arrangements, specialist advice for professionals is also available in most agencies through safeguarding leads. There is no evidence to suggest this pathway for support was utilised.

89. The investigation was managed in Devon and Cornwall Police by the sexual offences domestic abuse investigation team (SODAIT) which is a specialist unit of the criminal investigation department (CID). It was explained part of the remit of the team is to investigate non recent reports of child abuse unless current safeguarding issues are identified, when the public protection unit’s (PPU’s) local safeguarding team would take responsibility for the case.

90. In Greater Manchester the investigation was continued by a CID officer who at the time was not a specialist in sexual offences or child abuse investigation.

91. The Reviewer was told that all Greater Manchester police detectives now have enhanced safeguarding training which includes wider safeguarding consideration. Despite victims being the main focus in any police investigation it is important that a whole family approach is taken by all officers and other professionals involved in order that concerns or risks to others, and opportunities to offer support are not overlooked. The Reviewer was told that a review of governance of safeguarding across the Greater Manchester Police area is ongoing, part of which would include scrutiny of safeguarding training.

**Recommendation 5**

**The Head of Public Protection for Devon and Cornwall Police and the associated Local Safeguarding Children Partnership(s) in Devon and Cornwall should provide assurance that the findings and learning from the review regarding Child V have been widely disseminated across relevant police teams in Devon and Cornwall including investigators and managers and in particular supervisory officers with responsibility for allocation, review and monitoring of non-recent abuse cases.**

**Recommendation 6**

**The Head of Vulnerability and Public Protection/Lead for Serious Crime Division in Greater Manchester Police should provide assurance that the findings and learning from the review regarding Child V have been widely disseminated across relevant police teams in Greater Manchester including investigators and managers and in particular supervisory officers with responsibility for allocation, review and monitoring of non-recent abuse cases.**

**Recommendation 7**

**The Head of Vulnerability and Public Protection/Lead for Serious Crime Division in Greater Manchester Police should provide assurance and evidence that training programmes for all staff managing and investigating safeguarding concerns include consideration of wider safeguarding issues, risk, pathways for referrals and seeking professional advice and support.**

**CONCLUSION**

92. The circumstances in any serious case review are tragic. The analysis and findings of the review for Child V (Child V) have identified areas of learning for all agencies involved.

93. For Child V, a routine and uneventful pregnancy took place with engagement from both parents. However, some opportunities were missed to enquire about family history, adverse childhood experiences and domestic abuse.

94. The review identified a gap in local provision, pre and post birth, of consistent advice and support for parents and carers regarding safe handling of infants and risks of shaking.

95. During the pregnancy, simultaneously in a different part of the country Father was being investigated for alleged non recent child sexual abuse. Consideration of wider safeguarding and subsequent information exchange did not occur.

96. After the birth good practice was demonstrated by the health visitor who was professionally curious whilst conducting thorough observations of Child V and the family, which was supported by detailed recording.

97. Sadly, Child V was seriously harmed by Father when she was just 7 weeks old.

98. Reviewing practice always provides an opportunity to reflect on ways in which services can be developed to provide better support to children and families. As a result of the significant incident which occurred in the life of Child V the following recommendations have been made for Tameside Safeguarding Children Partnership and other organisations connected to the case.

**Recommendations**

**Recommendation 1**

**The Tameside Safeguarding Children Partnership must require assurance from Public Health and relevant partners that a programme of awareness and prevention relating to abusive head trauma is developed, agreed and implemented for use across the partnership area with all parents and carers.**

**Recommendation 2**

**The Tameside Safeguarding Children Partnership Quality/Assurance sub group should require its members to provide evidence that the abusive head trauma awareness and prevention programme is being consistently provided as agreed by health partners and key messages are being reaffirmed by professionals across the partnership to ensure babies and children are protected from abusive head trauma at every opportunity.**

**Recommendation 3**

 **The Tameside Safeguarding Children Partnership should explore opportunities locally for professionals to be more aware of the significance of adverse childhood experiences and the importance of proactive professional enquiry regarding family histories to ensure improved social outcomes for children and their families remain a priority.**

**Recommendation 4**

**The Tameside and Glossop Integrated Care NHS Foundation Trust should provide evidence and assurance that the Domestic Abuse in Pregnancy: Safe Routine Enquiry, Recording and Reporting Policy is being used appropriately, that enquiries relating to domestic abuse in pregnancy and new motherhood are undertaken and recorded in an accessible format, in order that mothers and babies can be safeguarded.**

**Recommendation 5**

**The Head of Public Protection for Devon and Cornwall Police and the associated Local Safeguarding Children Partnership(s) should provide assurance that the findings and learning from the review regarding Child V have been widely disseminated across relevant police teams in Devon and Cornwall including investigators and managers and in particular supervisory officers with responsibility for allocation, review and monitoring of non-recent abuse cases.**

**Recommendation 6**

**The Head of Vulnerability and Public Protection/Lead for Serious Crime Division in Greater Manchester Police should provide assurance that the findings and learning from the review regarding Child V have been widely disseminated across relevant police teams in Greater Manchester including investigators and managers and in particular supervisory officers with responsibility for allocation, review and monitoring of non-recent abuse cases.**

**Recommendation 7**

**The Head of Vulnerability and Public Protection/Lead for Serious Crime Division in Greater Manchester Police should provide assurance and evidence that training programmes for all staff managing and investigating safeguarding concerns include consideration of wider safeguarding issues, risk, pathways for referrals and seeking professional advice and support.**

**References**

* Working Together to Safeguard Children (Department for Education 2015
* Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulations 2006
* The Child Practice Review process (Protecting Children in Wales, Guidance for Arrangements for Multi-Agency Child Practice Reviews, Welsh Government, 2012)
* The Munro Review of Child Protection: Final Report: A Child Centred System, May 2011
* Healthy Child Programme 0-5 years Policy, Tameside and Glossop Integrated Care NHS Foundation Trust V6, February 2019
* CORE-INFO Head and spinal injuries in children, NSPCC and Cardiff University, May 2014
* Abusive Head Trauma: The Case for Prevention- Dr Suzanne Smith PhD, Winston Churchill Memorial Trust Travel Fellowship, 2016
* ICON, iconcope.org
* Kesler et al, Demographics of Abusive Head Trauma in the Commonwealth of Pennsylvania, 2008
* Domestic Abuse in Pregnancy: Safe Routine Enquiry, Recording and Reporting, Tameside and Glossop Integrated Care NHS Foundation Trust, November 2017
* Domestic abuse in pregnancy, [www.nhs.uk](http://www.nhs.uk)

**Statement by Reviewer**

**Reviewer**

*Amanda Clarke* (Independent)

I make the following statement that prior to my involvement with this serious case review-

 • I have not been directly concerned with the subject child or significant others connected to the child and have not given professional advice on the case.

• I have had no immediate line management of the practitioner(s) involved.

 • I have the appropriate qualifications, knowledge and experience and training to undertake the review.

• The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the terms of reference.

**Reviewer (Signature)**

*A.Clarke*

**Name**

Amanda Clarke

**Date** 03 February 2020

**Appendix A**

Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulations 2006 sets out the functions for LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1) (e) and (2) set out an LSCB's function in relation to serious case reviews (SCRs), namely:

5. (1) (e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

 (2) For the purposes of paragraph (1)(e) a serious case is one where:

 (a) abuse or neglect of a child is known or suspected; and

 (b) either (i) the child has died; or (ii) 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.

Cases which meet one of the criteria (i.e. regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii)) must always trigger an SCR. Regulation 5(2)(b)(i) includes cases where a child died by suspected suicide. Where a case is being considered under regulation 5(2)(b)(ii), unless there is definitive evidence that there are no concerns about inter- agency working, the LSCB must commission an SCR.

**Appendix B**

**SERIOUS CASE REVIEW CHILD V- BACKGROUND AND TERMS OF REFERENCE**

**Background**

Child V suffered brain damage in (date removed) 2018 and the characteristics of Vs condition are said to have been caused by a Non Accidental Injury and are consistent with being “shaken”. There is currently (September 2018) an ongoing criminal investigation into the injuries sustained.

A multi-agency panel established by Tameside LSCB will conduct the review and report progress to the Board through its Chair.

Membership will include an Independent Reviewer and representatives from key agencies with involvement.

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| **Organisation** | **Name** | **Role** |
| Independent  | Amanda Clarke | Independent Reviewer/ Chair |
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**Timeframe for the review**

The review will cover the timeframe of 24/08/2017 when the pregnancy was booked and 16/05/18 when an interim care order was granted. Any significant incident relevant to the case but prior to the start date of the timeframe may be included in the analysis completed by each agency.

**Subject(s) of the review**

Child V

**Significant others**

Child V’s Mother

Child V’s Father

**Core issues and purpose**

The core issues and purpose of the review are:

* Determine whether decisions and actions in the case comply with the policy and procedures of named services and the relevant LSCB;
* Examine the effectiveness of information sharing and working relationships between agencies and within agencies;
* Examine the effectiveness of handovers, information sharing and working relationships across borders;
* Examine whether requests for assistance and action across different areas considered wider safeguarding and that relevant information /concerns was/were formally referred as necessary and appropriate;
* Determine the extent to which decisions and actions were focussed on the subject child, including decisions and actions made pre-birth;
* Examine to what extent safe handling advice and other support was provided to the carers, and what consideration was given as to who should receive such support;
* Explore the engagement of fathers by involved professionals;
* Explore whether risk factors, such as domestic abuse, substance misuse, parental mental ill health were appropriately considered and were responses effective;
* Explore responses to concerns relating to possible neglect, including whether existing policy/guidance is effective;
* Examine the involvement of other significant family members in the life of the child, and family support provided to the subject family;
* Establish any learning from the case about the way in which professionals and agencies work together to safeguard children;
* Identify any learning for the LSCB to consider in order that an action plan can be developed to support and improve systems and practice, where necessary.
1. Working Together to Safeguard Children (Department for Education 2015, and Regulation 5 of the Local Safeguarding Children Boards (LSCB) Regulations 2006, which sets out the functions for LSCBs. [↑](#footnote-ref-1)
2. The event was organised in line with Welsh Government guidance (*Child Practice Reviews: Organising and Facilitating Learning Events, December 2012*) [↑](#footnote-ref-2)
3. Health Visitors work in partnership with parents and carers to lead and deliver the full Healthy Child Programme. This is structured around five regular, planned universal health visitor reviews of the health and development of each child, Healthy Child Programme 0-5 years Policy, Tameside and Glossop Integrated Care NHS Foundation Trust V6 February 2019 [↑](#footnote-ref-3)
4. CORE-INFO Head and spinal injuries in children, NSPCC and Cardiff University, May 2014 [↑](#footnote-ref-4)
5. Abusive Head Trauma: The Case for Prevention- Dr Suzanne Smith PhD, Winston Churchill Memorial Trust Travel Fellowship, 2016 [↑](#footnote-ref-5)
6. ICON: I-infant crying is normal and will stop, C- comfort methods can soothe and the crying will stop, O- ok to walk away if the baby is safe and the crying will stop, N- never shake or hurt a baby

ICON is co-ordinated and supported by a national steering group based in Hampshire, iconcope.org [↑](#footnote-ref-6)
7. Kesler et al, Demographics of Abusive Head Trauma in the Commonwealth of Pennsylvania, 2008 [↑](#footnote-ref-7)
8. Domestic Abuse in Pregnancy: Safe Routine Enquiry, Recording and Reporting

Tameside and Glossop Integrated Care NHS Foundation Trust November 2017 [↑](#footnote-ref-8)
9. Domestic abuse in pregnancy, [www.nhs.uk](http://www.nhs.uk) [↑](#footnote-ref-9)