Serious Case Review
Overview Report

Isobel

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1. **Introduction**

1.1 Isobel was admitted to the Emergency Department in December 2017 following a prolonged seizure. She was found to have old and new retinal haemorrhages and sub-arachnoid haemorrhages. There was no bony injury or soft tissue injury. There was bruising to her face and knee. The child's parents had called an ambulance. The child’s father stated he had been responsible for Isobel during the previous night. He stated Isobel had pulled herself up to sitting position in her baby bouncer, rolled over and banged her head on the metalwork of the bouncer. He was unable to account for the mark on her left knee. The conclusion of the medical examination was that Isobel had suffered neglect, had suffered non-accidental bruising to face and left knee in the previous 24 hours, and a potentially life-threatening injury a few hours before her admission to hospital.

1.2 The case was referred to the Durham Local Safeguarding Children Board two days later, and a Serious Case Review Sub-Committee reviewed the circumstances in February 2018. The Sub-Committee was told there had been a previous incident of bruising in early November, when the child’s father stated that Isobel’s elder sibling had done this. Further information concerned a torn frenulum injury to the elder sibling in 2015.

1.3 The Sub-Committee recommended that on the basis of this information, the criteria for a Serious Case Review was met as the child had suffered serious harm and abuse was suspected to be a factor in the case. This recommendation was endorsed by the Local Safeguarding Children Board (LSCB) and a Serious Case Review was commenced.

1.4 The child’s father pleaded guilty to assault and at the time of completion of this Review and was sentenced to service a custodial sentence.

2. **Process and Methodology**

2.1 The LSCB established an Overview Panel in accordance with SCR procedures. The Overview Panel considered all the information available at the time and agreed to undertake a *Concise Review* within the meaning of the ‘Welsh Model’. A Concise Practice Review is possible where abuse or neglect of a child is known or suspected; and the child was neither on the child protection list nor a looked after child on any date during the six months preceding the date of the event.

2.2 Chronologies were received from all partner agencies and merged into one timeline. The Lead Reviewer prepared an initial analysis which was discussed by the Overview Panel. This

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analysis formed the basis for discussion at a Learning Event. In the ‘Welsh Model’, the Learning Event is a way of working closely with practitioners in reflecting on events, identifying lessons learned, and beginning to formulate actions. Following the Learning Event, the agency representatives developed action plans which, along with the findings, were synthesised by the Lead Reviewer into a draft Overview Report which was discussed and clarified in a meeting of the Overview Panel. This Report is the result of that process and methodology.

3. Independence of the Author

3.1 The Panel commissioned Kate Mitchell as Lead Reviewer and Independent Author. Kate Mitchell has been commissioned previously to undertake SCRs for Durham LSCB, but has not been employed by any agency in this County and is therefore independent of all agencies engaged in this SCR. Kate Mitchell has independently chaired and authored several Domestic Homicide Reviews in other counties, and has, since 2008, been commissioned in several areas and sectors to undertake independent reviews and development of services in domestic violence, substance misuse, children’s services and adult learning disability services. Prior to 2008, she was employed in the Probation Service, as a practitioner, team manager and senior manager in roles which involved working across disciplines including commissioning, with the Community Safety Partnerships, chairing MAPPA and representing the Service in the LSCB.

4. Overview Panel Membership

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<tr>
<th>Role</th>
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<tr>
<td>Lead Reviewer and Author</td>
<td>Independent</td>
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<tr>
<td>Business Manager</td>
<td>Durham LSCB</td>
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<td>Admin Co-ordinator</td>
<td>Durham LSCB</td>
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<td>Operations Manager</td>
<td>Families First, Durham County Council</td>
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<td>Detective Superintendent, Safeguarding</td>
<td>Durham Constabulary</td>
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<td>Health &amp; Wellbeing Lead</td>
<td>Education Development Service, Durham County Council</td>
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<td>Named Nurse Child Protection</td>
<td>Harrogate &amp; District NHS Foundation Trust</td>
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<td>Named Nurse Safeguarding and Looked After Children</td>
<td>North Durham CCG, Durham Dales &amp; Easington CCG and Darlington CCG</td>
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<td>Named Nurse Safeguarding Children</td>
<td>County Durham &amp; Darlington NHS Foundation Trust</td>
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<td>Service Manager</td>
<td>Harbour Support Service</td>
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5. Confidentiality

5.1 Working Together to Safeguard Children, 2015, sets out the requirement for publication in full of the overview report from SCRs:

“All reviews of cases meeting the SCR criteria should result in a report which is published and readily accessible on the LSCB’s website for a minimum of 12 months. Thereafter the report should be made available on request. This is important to support national sharing of lessons learnt and good practice in writing and publishing SCRs. From the very start of the SCR the fact that the report may be published should be taken into consideration. SCR reports should be written in such a way that publication will not be likely to harm the welfare of any children or vulnerable adults involved in the case.”

5.2 The Panel has taken steps to safeguard the confidentiality of the child and the family. Isobel is a pseudonym for the child at the centre of this Report and is used throughout this Report. Other members of the household are referenced by their relationship to Isobel. Dates of events have been generalised in a way that retains the meaning of the information without being specific; dates of birth have been removed, and other identifying factors have been minimised so far as possible.

6. Family Involvement

6.1 Members of Isobel’s family were contacted by the LSCB to explain the rationale and process of the Serious Case Review and were invited to contribute. Both parents wished to be involved and were met at their home by the LSCB Business Manager and Admin Co-ordinator.

6.2 There was a parallel criminal justice investigation ongoing throughout the timescale of this Review, which is likely to have limited and influenced the parents’ perspective of events. The Report therefore considers, but cannot give equal weight, to the views of family members and the contributions of agencies.

6.3 The family will be contacted when the Report is completed, to discuss the outcome of the Review and to discuss the LSCB’s plans for publication.

7. Staff Involvement

7.1 Practitioners and managers in services which had contact with the family historically, have contributed information which is included as context.

7.2 Practitioners and managers in services which had contact with the family during the timescale under Review, were involved in the Learning Event, unless they were engaged in the police investigation process. In that event, they were represented by a manager.

7.3 Records of contact between agencies and family members were used in the Review.
8. **Race, Religion, Language and Culture**

8.1 **Family Composition:**
- Mother born 1994
- Father born 1988
- Sibling born September 2015
- Child Isobel born July 2017

8.2 Isobel and her family are white British. We have no record of religious preference or practice.

8.3 Isobel and her older sibling lived with their biological parents. Her mother worked in childcare, and on maternity leave during the time period covered by this Review. Her father was not working during the period covered by this Review.

8.4 The family lives in a traditional mining village and is supported by maternal grandmother and maternal sister who live in the neighbourhood. There is no information about the involvement of paternal relatives in the household.

9. **The Scope of the Review**

9.1 The Review Panel, having received initial information from the agencies which had contact with members of the household, agreed Terms of Reference (available on request). These set out the following key lines of inquiry which related to risk assessment and subsequent decisions taken in respect of Isobel:

- **Was previous relevant information or history** about the child and/or household members known and considered in professionals' assessment, planning and decision-making in respect of Isobel?

- **How did professionals' knowledge of specific risk factors** (including violence and mental ill health) contribute to their risk assessment and planning? Were risk assessments clearly articulated and accurate to inform analysis of the risks and impact upon children?

- **Was information about specific risk factors** shared and understood across different disciplines? Consider whether the constraints of electronic systems and other information sharing processes affected the accessibility of information and the ability to assess risk.

- **Did the mother's professional status** influence risk assessments?

- **Is there evidence of professional competence in identifying cumulative risk factors** as well as immediate risks to children?

- **Is there evidence of professional curiosity** when stress in families is recognized, in order to understand the impact on the whole family (Think Family Approach)?

- **Do medical professionals understand the safeguarding process** including recognizing an immediate safeguarding concern, and the services available to support families? Are there
constraints impacting on medical professionals accessing safeguarding training? Are some basic training inputs being missed for medical professionals? (This question was extended to all health professionals, during the life of the Review).

- How did **power relationships** affect decision-making in this case? Did professionals consider it possible and appropriate to challenge a paediatrician’s decision that a torn frenulum was accidental and not identified as a safeguarding issue?
- Overall, were the respective **statutory duties** of agencies working with the children and family fulfilled?
- Overall, were there any **obstacles or constraints**, not listed above, that prevented practitioners or agencies from fulfilling their duties (consider knowledge and skills, resources, organizational issues, other contextual issues)?

9.2 The Welsh Model methodology for a Concise Review focuses on events in the year prior to the incident. However, it was established that the timescale in this Review started with the first referral to an agency, in May 2015, relative to the child’s mother’s pregnancy with her first child. Information prior to May 2015 is included for context.

9.3 The timescale for completing the Review has been adjusted to allow for commissioning and criminal justice proceedings.

10 **Context: Significant events in the family background (up to May 2015)**

10.1 The child’s mother was first known to agencies in 2009 when, as a teenager, she received support at school due to anger issues. There is no further record until 2014 when she presented at a hospital Emergency Department with a burn to her arm; she reported this to be a domestic accident, and said she was trying to get pregnant.

10.2 In 2009, the child’s father was seen in A&E and referred to TEWV\(^2\) after attempting suicide following a family argument. He received therapeutic intervention for six months in relation to anxiety and panic symptoms, a history of abuse by a parent, and ongoing difficulties in family relationships.

10.3 The child’s father has a record of previous criminal convictions commencing during schooldays with warnings and a reprimand. He was cautioned for criminal damage and battery in 2006/7. In November 2009 he was arrested and charged with Assault occasioning Actual Bodily Harm, Criminal Damage, and three offences of possession of knives/ weapons; and at Durham Crown Court in June 2010 was convicted and received a prison sentence of 12 months in total, suspended for 24 months, with a supervision order and a community treatment order (mental health). He also received a Restraining Order in relation to this ex-partner.

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\(^2\) Tees Esk and Wear Valley NHS Foundation Trust provides mental health and learning disabilities services across County Durham and Darlington, Teesside and most of North Yorkshire.
10.4 An assessment by TEWV indicated he had problems with anger, agitation, and impulse control, and noted a previous ADHD diagnosis. It was noted there was an element of planning in his offending and that he carried knives. There was no evidence of significant mental health problems.

10.5 In December that year, he moved in with a new girlfriend in June 2011 they separated. In October 2011, a probation officer expressed concern about his mental health when he reported receiving death threats. In February 2012 he was said to be in a new relationship and his new girlfriend expecting a baby. He was discharged in June 2012, when the treatment order ended, and no further mental health issues were identified.

10.6 This Review notes that the child’s father came to his relationship with the child’s mother with a history of poor familial relationships, mental ill-health, offending, violence and domestic abuse. His concern with the pregnancies of girlfriends may be significant in retrospect. The child’s mother came to this relationship with a history of a difficult adolescence, but no contra-indications in relation to her parenting capacity; the information available indicates that she had trained and was employed in childcare.

11 Significant events during the timeline. Practice Episode 1: 2015 – July 2017

11.1 In February 2015, the child’s mother was in the current relationship with the child’s father and pregnant with their first child. She was working in childcare and took maternity leave prior to the baby’s birth.

11.2 During an initial ante-natal care appointment in February 2015, the child’s father self-reported his offending and substance misuse history to the midwife, including stating that he had Attention Deficit Hyperactivity Disorder (ADHD), personality disorder, previous cocaine addiction, and a previous conviction for Assault occasioning Actual Bodily Harm. The midwife recorded an Antenatal Cause for Concern. This process has been reviewed and no longer applies; however, at the time (2015), the process consisted of a document which recorded a concern internally; it was not a referral. It was established by Panel inquiries that the Cause for Concern was reviewed by the Specialist Midwife and no further action was taken. Five weeks later, the midwife reviewed the Cause for Concern and submitted a referral to First Contact. It was returned due to insufficient information and resubmitted two weeks later, in early June.

11.3 This referral was allocated for a Single Assessment by a social worker which commenced on in early June 2015 and completed in August 2015. The Review Panel has seen the manager’s closure summary of that Assessment. The Assessment raised no concerns about the child’s mother’s ability to look after a baby. In relation to the child’s father, the summary stated there was no evidence or suggestion of domestic violence or of his substance misuse in the current situation. It is not clear whether the Assessment considered the history of violence and
domestic abuse. It was said that the child’s father appeared to have changed and received support from the child’s mother’s family who appeared capable of intervening if they had concerns.

11.4 Throughout this first pregnancy, the child’s mother presented with abdominal pains, urinary tract infections, and other physical symptoms. These physical symptoms may have indicated domestic abuse. This was not explored. The appointment with the clinic was not followed up. As pregnancy is a high-risk time for domestic abuse, and there was awareness of the child’s father’s history, it would have been appropriate to have seen the child’s mother alone and made enquiries. There was no record of routine inquiry during pregnancy and until two months after the birth of the first child.

11.5 Following the birth of the first child in September 2015, the health visitor recorded that the child’s mother had the ‘baby blues’ but had support. It is clear from the record that the health visitor was aware of the risk factors pertaining to the child’s father. The health visitor noted that the child’s father was dominant in conversations and the mother quiet, however there was no consideration that his behaviour might be indicative of domestic abuse. His behaviour in actively engaging with professionals may have been seen as a source of reassurance, for there is no evidence that his history of mental health, domestic abuse and violence was considered, and no evidence that the impact of these risk factors on parenting capacity, and therefore any risks to the child, were assessed.

11.6 It was recorded that there was no routine domestic abuse inquiry as the child’s father was present and no health discussion as grandparents were present. The reasons for not undertaking routine inquiry due to the presence of family members were properly documented; however, practitioners are expected to create opportunities for safe routine inquiry and the HDFT\(^3\) Trust Wide Domestic Abuse Guidance sets out how staff can respond effectively in this situation, for example, stating, ‘If someone is always with them, you may need to think up a pretext to get them on their own…’ and accepts that practice was not compliant with guidance in this case.

11.7 The baby was five weeks old when the father phoned the Urgent Care Centre and asked for medical advice regarding the baby being in pain. He was advised by a doctor over the telephone that the symptoms were consistent with colic, and to see the family GP if the baby did not settle. The Review Panel challenged this practice and believes the baby should have been seen and reviewed at Urgent Care.

11.8 The following day, the parents called an ambulance and the baby was taken to hospital and diagnosed with a tear to the frenulum. A small bruise on the top lip externally was also recorded. The parents’ account was that the baby had put a finger in the mouth, causing the

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\(^3\) Harrogate and District NHS Foundation Trust is the provider of health visiting services for this area.
torn. It was recorded that the child’s mother worked in childcare and there were no social concerns. The consultant paediatrician said there was no sign of risk or non-accidental injury.  
11.9 A routine referral had been submitted by Ambulance staff attending and on receipt of this, Children’s Social Care discussed with the health visitor and received assurance that there was no concern. As no consideration was given to a non-accidental injury, no Strategy meeting was held. There is no evidence of professional curiosity regarding the reason for this injury. There is no indication that professionals disagreed with this diagnosis.  
11.10 The Review Panel suggests that the explanation offered by parents was not plausible in view of the baby’s age and that professionals were inappropriately reassured upon being told that mother worked in childcare. The health visitor recorded that the child’s father was dominant in providing the reason for the injury, but there is no evidence that this information was documented in the health records for midwifery.  
11.11 The health visitor followed up this incident with the family and introduced a nursery nurse to support the child’s mother, to help with feeding issues, and baby massage to help with colic. Four days after the injury, the child’s mother was said to be low in mood, and on medication. Maternal mental health was not considered in relation to the very recent injury and potential safeguarding issues. On a visit to the home, the health visitor recorded that the child’s father took the lead in discussions and mother did not talk. The father said that the baby – aged five weeks – did not like scratch mitts and had taken them off and put fingers in the mouth, causing the injury. Again, this statement was not questioned.  
11.12 The health visitor spoke to the child’s mother the following week about the issue of the child’s father taking control, and the child’s mother agreed this was an issue but said she did not feel unsafe or controlled by him. In light of what was known about his risk factors, this discussion was an opportunity to further explore those questions.  
11.13 One month after the torn frenulum incident, the nursery nurse visited and observed the baby had scratches to the face. The parents stated this was caused by the family dog jumping on the baby while on the chair. The GP recorded these scratch marks as ‘hardly visible’. It is recorded that the health visitor had earlier given safety advice regarding the dog and the Review notes that this incident was not followed up in relation to potential neglect.  
11.14 In January 2016, the child’s father was arrested for affray and offered screening by TEWV due to his mental health history; no ongoing role for mental health was identified.  
11.15 Over the following twelve months, the baby was seen by clinic and GP on a number of occasions, presenting with minor health issues. It is clear that the child’s father remained closely involved in caring for the child, attending clinic and GP practice.  
11.16 In November 2016, the child’s mother was pregnant. It was recorded that she was treated in relation to glucose tolerance due to having a large BMI and therefore being at risk of diabetes; was taking depression medication, and had a history of Children’s Social Care involvement,
therefore, it was planned to submit a referral at 20 weeks. This was not done.

In early February 2017, the child’s father self-reported a domestic incident including damage to the home and an assault by himself against the maternal grandmother. He told police that the child’s mother had post-natal depression (the baby was now 16 months old and mother was four months’ pregnant) and was not cleaning the house satisfactorily, which had led to the incident. The police determined no further action as the victim, recorded as being the maternal grandmother, did not wish to pursue; a vulnerable child report was submitted to Children’s Social Care, GP and Health Visitor, and to Harbour⁴ for support. There is no evidence of communication with midwifery considering the mother was four months pregnant.

Harbour requires consent to provide a service and as the victim did not wish to pursue the matter, no consent was available.

Children’s Social Care recorded that the child’s father was remorseful and decided no further action would be taken. The health visitor followed up this incident with the child’s mother by attempting to discuss domestic abuse, which is good practice. However, following this conversation, the child’s mother missed the next four appointments, and when she attended four months later, in June 2017, the health visitor did not discuss domestic abuse. This could have been avoidance by the child’s mother. As the mother attended alone, the opportunity for routine inquiry was missed.

The Review notes that the domestic abuse incident in February potentially evidences a pattern of behaviour in which a perpetrator manipulates his environment through compliance/disclosure, and that reporting a partner’s mental health to agencies is a known feature of coercive control, in which a perpetrator seeks to establish themselves as caring and the victim as having problems.

The midwife and health visitor held an information sharing meeting which is good practice. However, no plan appears to have been made to explore the issues. It would have been an opportunity for the safeguarding referral to have been made.

12 FINDINGS – Practice Episode 1

The findings in relation to this practice episode, which concerns Isobel’s elder sibling, the first child of the family, are based on analysis of the chronology, discussions in Panel and the reflections of practitioners and managers at the Learning Event.

- Had the information about parental mental health and father’s background including the level of violence in prior domestic violence, been considered in assessment and decision making, the risk of domestic violence in this relationship should have been a significant concern. The

⁴ Harbour is a commissioned service working with families and individuals experiencing domestic abuse.
domestic abuse incident that occurred whilst mother was pregnant was seen in isolation and, therefore, determined to be Standard. As Standard, the incident would not meet the criteria for screening by the Multi-Agency Safeguarding Hub nor would it be shared with Children’s Social Care and other agencies.

- The midwife was sighted on the risks to children and submitted a timely Cause for Concern to Children’s Services.
- However, the midwife did not consider the possibility of domestic abuse in pregnancy when the child’s mother presented with physical symptoms.
- There was no evidence that the dual process of having the parallel processes of an internal Cause for Concern and an external referral form caused undue delay in triggering an Assessment. However, this process has since been reviewed and removed as part of improvements made to the safeguarding practice in health. There is now a single referral process which is triggered when a case meets the threshold for safeguarding concern.
- The Single Assessment, in August 2015, appears to the Review to have been over-optimistic and did not give appropriate weight to the static risk factors in the child’s father’s history, i.e. substance misuse, violence, domestic abuse, mental ill health.
- The self-reporting by father of his previous history of domestic abuse, mental health and substance misuse was accepted by professionals and there was a lack of professional curiosity to triangulate the self-reporting against the information held by agencies. Had the domestic abuse incidents self-reported by father been explored, practitioners would have learned that he had used weapons, was known to carry weapons and had strangled a previous partner, which should have heightened the level of concern and led to a different course of action being taken.
- Health visitors noted that father was controlling and dominant during their interactions with the family. On reflection, there should have been better planning to speak to mother alone.
- It would have been appropriate for disclosure to the child’s mother, of the father’s previous domestic abuse, via Clare’s Law\(^5\). The Strategy Meeting agreed there should be a disclosure, but on inquiry, the Review established that no disclosure request was then generated in the Police Service, and the action was not completed.
- There is a need to clarify that medical advice for babies is not given over the telephone, i.e. without examination.
- Agencies recorded that the Harbour service was involved, however, it was not, as the referral related to the victim of the incident, which was the maternal grandmother, and not the child’s

\(^5\) The Domestic Violence Disclosure Scheme - known as Clare's Law - is intended to provide information that could protect someone from being a victim of attack. The initiative is named after 36-year-old Clare Wood who was murdered by her ex-boyfriend in 2009.
mother. Professionals may therefore have been falsely reassured that the family was receiving an intervention; professional curiosity may have informed them otherwise.

- The domestic abuse incident in February 2017, when considering the child’s father’s history, potentially evidences a pattern of coercive control. This is reflected in a parallel pattern of controlling the family’s interactions with professionals. Detailed self-disclosure, remorse, and presenting as a caring father and partner in which the child or the child’s mother have the problems; his dominance in explaining incidents and injuries, meant professionals were reassured rather than alarmed, and their curiosity was diverted. This self-protective behaviour can be a form of disguised compliance, and effectively avoids taking personal responsibility. It is open to discussion, how much of this pattern was observable at the time of these events, whereas the Review has the benefit of hindsight; however, a clear lesson learned is that there is considerable potential to improve safeguarding by developing professionals’ risk assessment knowledge and skills and professional curiosity. Since this time, Harbour has introduced a Lead Professional system, and delivered training for Social Workers relating to developing thinking and practice in domestic violence including coercion and control; this awareness by practitioners could lead to different decision making in a similar incident in future.

- The torn frenulum incident in 2015 is considered to have been a significant missed opportunity to trigger a Strategy Meeting and an Assessment which could have led to a more detailed history of the family being obtained, resulting in an intervention. The child was five weeks old and in hindsight, given the mechanism of the injury and the age of the child, the explanation provided by parents was not plausible. The account of the parents, and the opinion of the paediatric consultant, should have been challenged and the matter escalated. There was no evidence of disagreement or challenge by either health or social care professionals, all of whom should have been aware of the significance of the torn frenulum. This indicated a lack of professional curiosity and some drift in professional values, in that practitioners in both health and social care accepted the view of the paediatric consultant, followed by one another’s reassurances, without any clear documentation to explain why they were not alert to the potential significance of the event. The Review Panel discussed the potential of power dynamics, in this case between paediatricians, who may be seen as having more medical expertise and authority, and other health and social care practitioners. Panel members exploring this issue in health agencies assured the Panel that there was evidence of a change since 2015: safeguarding is more visible in both acute hospitals, with additional named nurses in safeguarding who support and enable professional challenge where health professionals have concerns with decisions made by medical professionals. There has been training for health professionals in assessing a torn frenulum and there is high awareness of safeguarding in the acute services. The safeguarding nurses attend peer
meetings in both hospitals where cases are discussed and challenged with paediatric colleagues. CDDFT has an incident reporting system for any issues where safeguarding policies and procedures are not followed.

- Professionals engaged in the torn frenulum injury discussed that the child’s mother worked in childcare, which may have given the impression they were interacting with a peer professional, and this may have led to the injury being minimised or the parent’s explanations being accepted.
- Overall, the Review finds a lack of professional curiosity and challenge. Incidents were seen in isolation and assessed by single agencies in isolation. There appears to have been no appreciation of cumulative risk factors.
- The Review has not been able to evidence a level of professional competence in risk assessment knowledge and skills that reassures the Panel in safeguarding; and suggests that professionals in all agencies concerned with this case did not take account of static risk factors and demonstrated an over-reliance on dynamic risk factors.

13 Significant events during the timeline. Practice Episode 2: July 2017– November 2017

13.1 Isobel was born in July 2017. No concerns were identified by midwives, who phoned Children’s Social Care to confirm the case was closed.

13.2 Isobel was three days old and at home when a domestic incident involved the police. This was a verbal argument which is recorded by police as having been due to financial problems. The child’s mother took the children to the maternal grandmother’s house, and it is not clear how long she stayed there, as she was home ten days later when the health visitor called. It was assessed as Standard and agencies would therefore not have been notified.

13.3 At this visit, the health visitor observed that the first child, now 22 months old, was playing in the garden barefoot, and there were no toys in evidence. There was no analysis of this observation, and it is noted that this could have been an opportunity to assess risk and liaise with professionals. The health visitor asked about domestic violence when the child’s father was present, which is contrary to professional guidance.

13.4 The child’s mother attended clinic regularly with Isobel, always accompanied by the child’s father or by the grandmother. In August, the health visitor observed once more that the child’s father took the lead in all contacts, while the mother was quiet. Again, there was no analysis of this behaviour in considering coercive control. Two weeks later, the child’s mother told the health visitor she had a low mood and was going to attend counselling. Records do not reflect that the health visitor considered listening visits, completing the Edinburgh Postnatal Depression Scale, or assessing parenting capacity due to mental health problems. There is no evidence of liaison with the GP to ascertain a diagnosis or medication. Overall, these
records lack assessment and analysis and no further follow up by home visit was arranged despite concerns about the child’s mother’s mental health and significant risk factors from the child’s father.

13.5 Isobel had a number of health issues including two interventions for gastroenteritis and congestion in October. In early November, aged four months, Isobel was seen at clinic with her parents, with three bruises on her face. Her parents stated this was caused by her older sibling falling onto her. She had lost 9oz (sic) and this was said to be due to gastroenteritis. The bruising policy for non-mobile children was not followed. There was no consideration that the considerable weight loss could be due to neglect. This was a significant missed opportunity to safeguard both babies.

13.6 Seven days later, at clinic, a different health visitor observed the bruising to Isobel’s face and checked to confirm the earlier health visitor had documented it. Again, the bruising policy was not followed and there was no exploration that the weight loss could be due to neglect. There was no consideration of a growth review or other follow up.

13.7 Isobel was seen in surgery for wheezing and coughing the following day, and again four weeks later, in mid-December 2017, for coughing and a high temperature.

13.8 The following day, the parents called an ambulance and Isobel was admitted to hospital. The previous bruising was reconsidered. It was noted that the child’s mother remained quiet throughout the discussions with medical staff. The consultant attempted to speak to the child’s mother alone and recorded that the child’s father returned to the room.

13.9 Children’s Social Care was informed, and a Strategy meeting convened.

14 FINDINGS – Practice Episode 2

14.1 The findings in relation to this practice episode, which concerns Isobel, are based on analysis of the chronology, discussions in Panel and the reflections of practitioners and managers at the Learning Event.

- There was a missed opportunity in that the plan by midwifery to submit a safeguarding referral at the 20-week stage of mother’s pregnancy was not implemented.
- There was a key missed opportunity to safeguard both children when the ‘bruising to non-mobile babies’ pathway was not initiated; and when baby Isobel’s weight loss was not considered as potentially a sign of neglect, on two separate occasions. Injuries were looked at in isolation. Professionals accepted the parents’ explanation for injuries to a non-mobile baby. Since these events, the Policy and Procedure for Bruising in Non-Mobile Children has been reviewed and relaunched within agencies, however, the Review Panel is in agreement that there remains work to be done to review whether all staff are aware and implementing the procedure and to identify any remaining gaps.
- Overall, there was a lack of professional curiosity and challenge and no evidence that
the accumulation of risk factors had been considered. The child’s father’s violent history and issues regarding domestic abuse were known but did not trigger any further action or exploration in terms of the impact and risk to the children.

- There was evidence of communication and information sharing, but not that the information had been pulled together, analysed, and used to plan. Opportunities to convene a multi-agency meeting where it would have been possible to consider what the information meant for the children, were missed.

- The child’s mother’s professional role in childcare may have led to over-optimism when concerns might otherwise have resulted in action being taken. After the first pregnancy, when it is recorded that the child’s mother took maternity leave, her professional role became a static, protective factor that was not explored: there was no evidence that she remained employed two years later, where she was employed or whether she was qualified.

- The child’s mother reported mental health issues and an intention to commence counselling. This was not followed through using the assessment tools available to the health visitor, and there was no liaison with the GP to ascertain a diagnosis or medication. There was no consideration of the impact of ill health on parenting capacity and the children’s wellbeing and safety.

- The needs of the parents, particularly the child’s father, were uppermost and dominant, leading to a lack of child centred practice. The voice of the child was missing from assessments and decision making. The older sibling was verbal, and an opportunity was missed to empathise with the lived experience of the children when the health visitor observed there were no toys visible.

- There was an over-reliance by professionals on the self-reporting by parents and notably, on what the father was telling professionals. The child’s father was ever-present and dominant whilst the child’s mother was silent and effectively invisible.

- There was an assumption by professionals that maternal grandmother was a protective factor, without evidence. It is recorded that when maternal grandmother attended clinic with the child’s mother, she was dominant and the child’s mother quiet, an observation which was not explored.

- The child’s mother was asked about domestic abuse in the presence of her partner which is not compliant practice.

- This domestic abuse incident, as the incident during the first practice episode, was graded as Standard and therefore did not meet the criteria for screening by the Multi-Agency Safeguarding Hub or to be shared with Children’s Social Care.

- On Isobel’s admission in December, there was a timely medical report, and liaison with
police and children's services.

- Overall, the Review found a number of significant opportunities that were missed during Isobel's life: to use the information gathered over previous contacts, about the parents, to challenge their account of incidents, explore and synthesise known information, and to implement safeguarding procedures.

15 Lessons Learned – Key Lines of Inquiry

Was previous relevant information or history about the child and/or household members known and considered in professionals' assessment, planning and decision-making in respect of Isobel?

15.1 Previous relevant information or history was insufficiently considered. The significance of the child's father's history of violence and domestic abuse, including a Restraining Order, did not properly inform assessments and decision making, which the Review finds were over optimistic. The child's father self-disclosed previous ADHD, cocaine addiction, and personality disorder, which caused concern for the family's first midwife, who referred the matter forward, and an assessment was completed by Children's Services which identified no concerns. It was the view of the Panel that use of historical information, such as from TEWV regarding his problems with anger, agitation and impulse control, and that he used weapons and the circumstances of the serious domestic violence in the past, may have raised concerns about immediate risks.

15.2 There was no previous relevant information regarding the child's mother that could have raised a cause for concern.

How did professionals' knowledge of specific risk factors (including violence and mental ill health) contribute to their risk assessment and planning? Were risk assessments clearly articulated and accurate to inform analysis of the risks and impact upon children?

15.3 As noted above, a midwife referred to Children's Services in 2015. There is no evidence that subsequent professionals understood the significance of the specific risk factors relating to the child's father. The Review found the assessment by Children's Services did not sufficiently reference the child's father's historical risk factors and was over optimistic in believing the child's father had changed. Professional knowledge and understanding of risk should include an evidenced assessment of how static risk factors (addiction, violence, domestic abuse) are currently managed and minimised, and how a plan can further minimise those risks.

15.4 In ante natal care, potential indicators of domestic violence were not explored in either pregnancy. There was no routine inquiry. Pregnancy is the highest risk period for domestic
abuse.

15.5 The child’s mother’s mental health was reported by herself when she was feeling low, and when she received medication, and by the child’s father. This was noted but not explored, either as a specific risk factor in terms of her parenting capacity, or as an indication of coercive control in the relationship.

15.6 All practitioners missed the opportunity to see the elder sibling’s torn frenulum as an indicator of non-accidental injury. Health visitors, whilst alert to financial stress in the relationship, and aware of the child’s father domination of conversations between the child’s mother and professionals, were not alert to the significance of bruising in a non-mobile baby.

15.7 Overall, the Review finds that practitioners did not evidence the knowledge and skills in assessing how static risk factors in the child’s father’s history affected his parenting capacity, and how, aggravated by dynamic risk factors such as current stresses in finances and in the relationship, and the child’s mother’s mental health, would influence parenting capacity. With this knowledge and understanding, a number of incidents including domestic violence, torn frenulum and bruising would have created an immediate safeguarding alert and action to protect both children.

Was information about specific risk factors shared and understood across different disciplines? Consider whether the constraints of electronic systems and other information sharing processes affected the accessibility of information and the ability to assess risk.

15.8 There is no evidence that information sharing processes were constrained by systems.

15.9 Opportunities for conferencing, when information about specific risk factors could have been shared and understood across disciplines, were missed, notably when the initial cause for concern was recorded by the midwife in the first pregnancy. There was an assessment by Children’s Services which is considered an incurious assessment based on self-reporting by the family. There is no policy requirement for conferencing in these circumstances, however, accessing historical information from TEWV may have resulted in significant information regarding the child’s father and behaviour being more fully assessed.

15.10 The Review finds that the torn frenulum of the elder sibling was an important missed opportunity to investigate non-accidental injury and, in that process, to share information across disciplines.

Did the mother’s professional status influence risk assessments?

15.11 The Review suggests that professionals were reassured by the belief that mother worked in childcare. This may have been so, when pregnant with the first child; however, there is no
evidence that mother’s qualifications or employment status were verified at any stage by any professional.

Is there evidence of professional competence in identifying cumulative risk factors as well as immediate risks to children?

15.12 The static risk factors, combined with current information, including the recorded incidents, created an accumulation of risk factors. However, information about risks was not synthesised by professionals, and opportunities to identify immediate risks to both children, were missed. Key points for identifying immediate risks to the children including the torn frenulum of the elder sibling, and the bruising to a non-mobile child, and the weight loss of Isobel, were missed.

Is there evidence of professional curiosity when stress in families is recognized, in order to understand the impact on the whole family?

15.13 Financial stress was recorded on one occasion, as being the child’s father’s account of the trigger factor for an incident of domestic violence. He also stated that there was stress because the child’s mother was not cleaning satisfactorily. There is no evidence that these stresses, or that the stresses impacting on the child’s mother’s mental health, were explored.

15.14 The voices of the children, one of which was verbal at the relevant time, were not evident in this Review. The voice of the child’s father was dominant, and recorded as being so, to the extent that the mother’s voice was rarely heard. As such, practitioners could not have developed an awareness of the lived experience of the children, or of the children’s mother. Practitioners appear to have been reassured by the voice of the father. Observations, such as the absence of toys, financial stress, and dominance of father, were not explored.

15.15 Overall, the Review found little evidence of professional curiosity in terms of exploring and understanding what was happening in the family rather than making assumptions. Those assumptions were largely based on the child’s father’s communication, which had already been identified as dominant, and potentially controlling, yet appear to have reassured social workers and health visitors. The impact of the child’s father’s previous history on his relationship with the child’s mother, and on his parenting capacity, and therefore the implications of this history, aggravated by current stresses, for the family, were not recognized. Professionals appear to have been reassured without evidence.

Do medical professionals understand the safeguarding process including recognizing an immediate safeguarding concern, and the services available to support families? Are there constraints impacting on medical professionals accessing safeguarding training? Are some basic training inputs being missed for medical professionals?
15.16 These questions concern training in safeguarding process, not only in the issues of raised in this Review. Whilst safeguarding training is mandated and monitored, and accessible to all medical staff, these are busy health professionals who may not be able to prioritise attendance. There is evidence of gaps in knowledge of processes, for example, when Isobel was taken to emergency on the final occasion, this triggered a referral to Children’s Services immediately. However, there was no communication with the hospital safeguarding team for two days. The recommendations include seeking assurance that training has been implemented effectively in all agencies and that all professional staff have been trained.

15.17 It was agreed by the Review Panel that these questions applied to all health care staff, who comply with an intercollegiate safeguarding framework, and not only medical staff, and therefore the accompanying recommendation will reference health professionals.

How did power relationships affect decision-making in this case? Did professionals consider it possible and appropriate to challenge a paediatrician’s decision that a torn frenulum was accidental and not identified as a safeguarding issue?

15.18 In the incident of the torn frenulum, there is no indication that the assessment of accidental injury was disagreed by any other professional involved. The account of the child’s father that the child had caused the injury does not appear to have been questioned. Whilst there was no information presented to the Review to suggest that hierarchical positions influenced decision making, it was reflected at the Learning Event that there may be an over reliance by professionals on medical opinion.

15.19 The Review Panel concluded that hierarchy and status did influence decision making, and this case had demonstrated that experienced professionals in health and social care can be influenced by medical expertise and authority. This will be reflected in the recommendations in relation to challenge and escalation.

Overall, were the respective statutory duties of agencies working with the children and family fulfilled?

15.20 There were gaps in compliance with statutory duties. For example, neither the health visiting service nor midwifery followed guidance in relation to routine inquiry (domestic abuse) during and after the pregnancy because either the child’s father or other family members were present. There was no decision to explore the torn frenulum by convening a Strategy Meeting.

15.21 On two occasions in November 2017, when Isobel was seen at clinic with three bruises on her face and having lost a significant amount of weight, her parents’ account was accepted,
neglect was not considered, bruising policy was not followed, and no growth review was arranged. The matter was not referred for safeguarding advice. This was the key missed opportunity to safeguard both babies.

15.22 Police officers responding to the domestic abuse incidents graded these as Standard and therefore no action followed, which is in accordance with policy and procedures. It is not known whether the child’s mother was aware of the father’s previous domestic violence. That previous incident was very severe, and the Review noted that a Clare’s Law disclosure had been agreed and was not implemented.

Overall, were there any obstacles or constraints, not listed above, that prevented practitioners or agencies from fulfilling their duties (consider knowledge and skills, resources, organizational issues, other contextual issues)?

15.23 Staff in all agencies concerned were trained and experienced practitioners. There was consistency in staffing in all services and no staffing or other resource constraints were identified during this Review.

16 Recommendations

16.1 These recommendations reflect findings of this Review. Recommendations 1 – 3 are overarching multi-agency development needs; the remaining recommendations were submitted by individual agencies.

<table>
<thead>
<tr>
<th>Theme: Multi-Agency Training and Development</th>
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<tr>
<td><strong>Recommendation 1:</strong></td>
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<td>Review the multi-agency safeguarding training and improve or introduce a module concerning risk assessment. Develop skills and knowledge of risk assessment, to enable practitioners to formulate evidence-based assessments which include: historical risk factors and how these can be managed and minimised through multi-disciplinary planning; the role of dynamic risk factors in aggravating or minimising risks to children; cumulative risks; and the recognition of immediate risks of harm to children.</td>
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**Target Group:** Midwives, Health Visitors, Social Workers

**Lead:** DSCP
Recommendation 2:
Review the multi-agency safeguarding training and improve or introduce a module concerning professional curiosity (the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value). The aim is to enable front line staff to explore risk information that is known or disclosed in their contacts with families.

**Target Group:** Social Workers, Midwives, Health Visitors, Police Officers  
**Lead:** DSCP

Recommendation 3:
Partnership agencies to brief health and social care and police staff on the findings relating to risk assessment and plans for improvement, using this Review as an anonymised example.

**Target Group:** Social workers, police officers, health practitioners, and their line managers.  
**Lead:** Children’s Services (CYPS), Health Visiting Service (HDFT), Midwifery Service (CDDFT), Police Service (DPS)

**Theme:** Risk Assessment

Recommendation 4:
Improve the recognition of risk, analysis of information gathered, and subsequent actions taken, to support children and families, by auditing the new Midwifery Risk Assessment Tool to evidence its impact, and take action as required to fully implement the Tool.

**Target Group:** Midwives  
**Lead:** CDDFT

Recommendation 5:
Improve the assessment and recognition of risk with babies aged under three months, by reviewing and amending the process of telephone triage in the light of the findings of this Review. This includes exploring access to risk assessments via SystmOne, by Urgent Care Staff.

**Target Group:** Urgent Care Departments  
**Lead:** CDDFT and CCG

**Theme:** Mental Health and Parenting Capacity

Recommendation 6:
Develop health professionals' awareness of mental health issues that can impact on the ability to parent, and the sharing of information so that fuller assessment of parenting capacity can be made and therefore, a better risk assessment.

**Target Group:** General Practitioners and Practice Managers  
**Lead:** CCG
**Theme: Domestic Violence**

**Recommendation 7:**
Review the practice of not automatically escalating domestic abuse incidents involving pregnant women to Medium Risk. Consider whether pregnancy is an aggravating factor and what action could be taken in the light of findings of this Review.

**Target Group:** Police Safeguarding Unit

**Lead:** Domestic Abuse and Sexual Violence Executive Group

**Recommendation 8:**
Agencies to introduce a Strategy De-brief to ensure decisions agreed at a Strategy Meeting have been allocated. For example, that a Clare’s Law Disclosure has been tasked and completed.

**Target Group:** Social Workers, Police Officers and Police Safeguarding Unit.

**Lead:** Children’s Services

**Recommendation 9:**
Improve the recognition of risk, analysis of information and actions taken to support children and families, by reviewing and amending hospital midwifery documentation to ensure it includes, within the holistic assessment, specific indicators for domestic abuse including triggers for increased risk.

**Target Group:** Midwives

**Lead:** CDDFT

**Recommendation 10:**
Develop skills in identifying coercive control in family relationships and exploring and understanding the impact of this on children by:

a) Sharing the learning on Domestic Violence and Abuse to enable staff to feel confident in undertaking a risk assessment and analysis of domestic violence and abuse. The key messages are: to be aware of the vulnerability of babies, children and young people living with domestic abuse; and to recognise, respond and reduce the risks posed to children living in households where there is domestic abuse.

b) Where there is an indication or information of domestic violence or abuse in a household, historically or currently, continuously assess risks through the staff supervision process; challenge thresholds, support professional curiosity, and enable planning for intervention.

c) Record-keeping needs to evidence this continuous assessment and planning process.

**Target Group:** Health Visitors

**Lead:** HDFT
Recommendation 11:
Improve the screening and identification of pregnant women who may be at risk of domestic violence to enable appropriate support services to be offered, by providing domestic violence and abuse training to all midwives.

Target Group: Midwives
Lead: CDDFT

Theme: Voice of the Children

Recommendation 12:
The voice of the child needs to be captured effectively, and their lived experience understood, considered and acted upon, by practitioners and line managers in risk assessment, planning, and decision making.

Target Group: Health Visitors and Social Workers
Lead: HDFT and Children’s Services

Theme: Policy and Procedures

Recommendation 13:
Durham Safeguarding Children Partnership to seek assurance through a multi-agency audit that there is compliance in agencies with procedures for responding to bruising in non-mobile babies. These procedures have been re-issued to all staff through a series of briefings. Action is to be taken where gaps in awareness or practice are identified through the audit.

Target Group: Health Agencies.
Lead: DSCP

Theme: Decision Making

Recommendation 14:
Improve the assessment and recognition of non-accidental injury to babies, and the subsequent decision making, by sharing the learning from this and previous reviews with specific reference to Non-Accidental Injury with paediatric staff. Audit the impact of this action.

Target Group: All Paediatric Staff
Lead: CDDFT
Recommendation 15:
Evaluate the current process of collating and triangulating information on families through Multi-Agency Safeguarding Hub and Strategy discussions, against the findings of this Review. Implement any developments required to ensure the process is comprehensive and supports defensible decision-making in managing the cumulative risks in households and that this management oversight is recorded.

**Target Group:** Social Workers and Team Managers

**Lead:** Children’s Services

Recommendation 16:
Management oversight of decision-making in risk assessment and planning in child and family assessments is to be made clear through recording all discussions and actions/ expectations concerning decision-making. Quality assure the assessment and decision-making process to ensure that decision making is evidenced, through themed audits and through implementation of the Signs of Safety Model.

**Target Group:** Team Managers

**Lead:** Children's Services