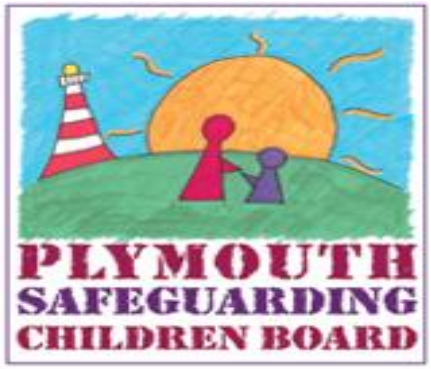

SERIOUS CASE REVIEW

BABY F

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Report author:
Karen Tudor
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INTRODUCTION

Events leading to this Serious Case Review

1. This Serious Case Review (SCR) concerns an 11 week old baby, known as Baby F, who in September 2016 suffered a life-changing head injury. Baby F was admitted to hospital, medically examined and in addition to the head injury, was found to have a number of rib fractures and a healing rib fracture. His parents were arrested and charged in connection with the injuries; a trial is listed to take place in 2018.

2. Baby F was born in the summer of 2016, he is the first child of both his parents, they were living together and report they had been in a relationship for about two years. Baby F's parents are a well educated, professional couple, both of whom have a complex childhood history and neither of whom had any local family support.

3. There were indications, from the beginning of Baby F's life, that his parents struggled with the demands of a new baby and both parents were diagnosed with post-natal depression and were being treated by their respective GPs. Baby F's mother had also been referred for counselling. On two occasions, prior to the head injury, Baby F was taken to the local hospital with unusual medical presentations which were not considered significant at the time.

4. After the diagnosis of the head injury, Baby F spent a number of weeks in hospital before being placed with foster carers. His injuries are life changing, for example at the age of ten months, his development appeared to be that of a baby aged two to three months.

Conducting a Serious Case Review

5. When abuse or neglect of a child is known or suspected and either the child has died or been seriously harmed and there is cause for concern as to the way in which services have worked together to safeguard the child, the Local Safeguarding Children Board (LSCB) has to consider whether a Serious Case Review should be carried out.

6. The Plymouth Safeguarding Children Board (PSCB) under Regulation 5 of the Local Safeguarding Children Boards Regulations, 2006, decided the criteria were met for a SCR. The recommendation was confirmed by the Chair of the PSCB and notification of the decision was made to the Department for Education.

7. The purpose of the Review as defined by Working Together is:
    - To establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children

- Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result
- As a consequence, improve interagency working and better safeguard and promote the welfare of children[1]

The Process of the Review

8. An Independent Reviewer was commissioned and the process overseen by a Serious Case Review Group, this is a sub group of the Local Safeguarding Board comprised of senior managers and clinicians none of whom had had direct involvement with the case; this group set out the terms of reference and agreed the review would cover the period leading up to Baby F's birth (the pregnancy) until the date the injuries were diagnosed, a period of just over a year.

(See Appendix for a list of SCR Group members)

Parallel Investigations/Enquiries

9. Because of the criminal proceedings, the SCR was conducted in accordance with the guidance "Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews."[2] This guidance suggests a framework for the sharing and exchange of relevant information generated by Serious Case Reviews and a criminal prosecution to prevent one adversely affecting the other. Working within this framework enabled the Safeguarding Board to ensure there was no unnecessary delay in concluding the SCR because of the criminal proceedings and identify any learning as soon as possible after the events.

Method

10. The Review must be conducted in line with government guidance, Working Together to Safeguard Children, 2015. In view of the move towards using systemic models and practitioner involvement to promote learning, the Board decided to use a review model known as a Partnership Learning Review. Involving practitioners, the baby's family and working with the Serious Case Review Group, the Review addresses the question of who did what and why and identifies Themes for Learning. The methodology also recognises that people work in complex organisations where a range of factors can impact on the nature of the work and where relevant, these are reflected in the analysis.

[1] Working Together to Safeguard Children, 2015

[2] Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews, A Guide for the Police, Crown Prosecution Service and Local Safeguarding Children Boards, May 2014

11. A chronology of events was requested from the agencies who had worked with the family, and, because it was not advisable in light of the criminal investigation to hold meetings of practitioners, those who had worked with the family were invited to meet the Independent Reviewer individually or in single agency groups. The findings are reflected in the Learning Points and Considerations for the Safeguarding Board.

(See Appendix for a list of agencies involved.)

12. As part of the analysis, the Independent Reviewer was asked by the SCR Group to consider the following questions
    - The degree to which parental mental and emotional health influenced the multi-agency service response
    - To what extent were the ethnicity and educational status of the parents taken into account in the assessment and identification of risk and to inform professional decision making and subsequent action
    - The assessment of risk during key contacts
    - The understanding and application of threshold

Family Involvement

13. After discussion with the Crown Prosecution Service, in order to ensure evidence for criminal proceedings was not compromised, the mother and father of Baby F were invited to contribute to the Review in writing. They were contacted by the Independent Reviewer and asked their views on the services they had received; the parents declined the request to participate in the Review.

Anonymity

14. For the purposes of publication of the report, details of the family history and current circumstances are kept to a minimum. The names of individuals have been anonymised, family members are:

    - Baby F – Subject of Review, born in July 2016, Baby F is of African/European heritage
    - Ms M – Baby's F's mother, aged in her early 20's
    - Mr F – Baby F's father, aged in his late 20's

KEY EVENTS

Early 2016	Booking with midwife, Ms M says she has mental health problems and history of anxiety and depression, a history of "family problems." Health Visiting team informed about Ms M's history of low mood and depression.
Summer 2016	Member of Ms M's extended family very ill, Ms M described as "very stressed."
Summer 2016	Baby F born by emergency Caesarean Section, birth weight 2.5kgs/ 5.8lbs Ms M initially anxious, not wanting to be alone with Baby F but later calms and "eager to go home."
Baby aged 3 days	Handover from Midwifery to Health Visiting Service for ongoing support in line with usual practice. Ms M placed on enhanced HV visiting programme, for weekly visits.
Baby aged 10 days	Health Visitor home visit – baby weighed, slight weight loss, within normal limits for a newborn baby. Ms M expressing some anxiety, advised to see GP if worsens, observed gently handling and emotional warmth from Mr F.
Baby aged 2 weeks	Ms M has first appointment with work place counselling service.
Baby aged 4 weeks	Ms M sees GP about anxiety and depression and is having counselling from work place service. Baby F is offered a place at a local nursery.
Baby aged 5 weeks	Parents call ambulance, Baby F, aged 5 weeks, admitted to hospital overnight, "unwell, crying and blood in mouth/vomit" Health Visitor and GP notified after discharge.
Baby aged 5-6 weeks	Baby F sleeping downstairs with Mr F as Ms M not waking for him during the night. Health Visitor notes Ms M reporting anxiety worsening and tensions within her relationship with Mr F. Ms M discussed anxiety with GP, to self-refer for additional counselling.
Baby aged 6-8 weeks	Ms M has three appointments with the work place counsellor, her anxiety continues.
Baby aged 8 weeks	Ms M sees GP and is diagnosed with post-natal depression.
Baby aged 8 weeks	Baby F seen at hospital, "small bilateral conjunctival haemorrhages, grumpy and not settled" discharged with "advice."
Baby aged 8 weeks	Baby F attends nursery, Mr F tells Health Visitor he is feeling low.
Baby aged 9 weeks	Mr F has telephone consultation with his GP and reports he has symptoms of post-natal depression, thoughts of harming Baby F and of self-harm but reassures GP he is in control and won't act on his

	feelings, is prescribed medication and referred for counselling. Mr F is assessed by the counselling service during a telephone call; he is offered an appointment after the period of this review.
Baby aged 9 weeks	Baby F attends nursery, has small mark on cheek, staff report it could be pigmentation or small bruise, discussed by nursery staff, no action taken.
Baby aged 10 weeks	Ms M tells the counselling service that Mr F had banged the baby's head; Counsellor took advice from supervisor, reassured by Ms M's demeanour, no action taken.
Baby aged 11 weeks	Mr F telephones GP and is advised to bring baby to surgery immediately, Baby F has swelling on head, allegedly from hitting head on work surface during a feed, ambulance takes Baby F to hospital where he is found to have life threatening head injuries, an intra-cranial haemorrhage and rib fractures and an older rib fracture.
Autumn 2016	Child Protection Investigation initiated followed by Care Proceedings.
	The criminal investigation was ongoing at the time of writing; a trial was expected to take place in 2018.

LEARNING THEMES

15. From the documentation provided and meetings with the practitioners involved with the family, the following learning themes emerged:

- Identification and Response to Post-Natal Depression
- Response to unusual medical presentations in pre-mobile babies
- Knowledge and Understanding of the Child Protection Procedures and Thresholds for Referral
- Adult Services Working with Parents and their Responses to Safeguarding Concerns about Children

IDENTIFICATION AND RESPONSE TO POST-NATAL DEPRESSION

Identification

16. Post natal depression is a well recognised condition which is said to affect an estimated 13% of women following childbirth. Research shows that it can have an enduring effect on both the mother's health and their child's development; for example there is a substantial body of research showing consistent associations between maternal post-natal depression and an increased risk of cognitive, emotional, and behavioural problems in children.[3]

17. Symptoms of post-natal depression include persistent feelings of sadness and low mood, lack of energy and feeling tired all time, difficulty bonding with the new baby and can include frightening thoughts for example about hurting the baby.

18. Factors associated with post-natal depression include a parent's history of mental health problems, particularly depression in earlier in life, having no support from family or close family, a poor partner relationship and recent stressful life events such as bereavement[4].

19. Ms M described herself as having most of these symptoms and the associated factors, which meant her presentation was seen as typical by the health professionals working with her.

20. What is less well documented, or generally understood, is the concept of post-natal depression in fathers. Believed to affect 5%-10% fathers, it is most commonly considered to be a risk for men when the baby is 3 - 6 months old;[5] the factors associated with post-natal depression in fathers are similar to those of mothers, although research indicates that stress in the parents relationship is of greater significance for men; also the effects on the child may be particularly potent when the depression occurs very early in the child's life.[6]

21. In this case both parents were diagnosed with post-natal depression. For Mr F, the diagnosis of post-natal depression was much more unusual in that the majority of health staff who knew this family had either never heard of post-natal depression in fathers or never come across it before.

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[3] Postnatal depression : the impact for women and children and interventions to enhance the mother-infant relationship, *01 June 2011 - Publisher: National Childbirth Trust*

[4] NHS, Post-natal Depression, 2016

[5] Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health, Janice H. Goodman Journal of Advanced Nursing Volume 45, Issue 1, pages 26–35, January 2004

[6] Paternal depression an examination of its links with child and family functioning in the post natal period, Paul G Ramchandani et al, Journal of Psychiatry, June 2011.

The effects of early paternal depression on children's development, Richard J Fletcher, Emily Feeman, Craig Garfield and Graham Vimpani, Med J Aust 2011; 195 (11): 685-689.

Fathers and Post-natal Depression, The fatherhood Institute Research Summary, August 2010.

Learning Point:

- Fathers can experience post-natal depression, the signs and symptoms are similar to those of mothers and the potential effects on children are equally serious.

Response to Post-Natal Depression

22. Regarding Baby F's mother, the sequence of events leading up to Baby F's birth was not perceived by the health workers as anything out of the ordinary.

23. Ms M had attended her ante-natal appointments with midwifery, information about her history was discussed and a brief assessment carried out to determine if Ms M had any particular issues with her pregnancy or in her family life which would have led to signposting to community services, for example the local Children's Centre, or an enhanced or specialist service from midwifery. Although Ms M reported some anxiety and issues from her childhood, these did not indicate to those working with Ms M that there was a need for any additional work. There was nothing in Ms M's contact with the midwives which made her stand out.

24. Baby F was born by Caesarean section at the beginning of July following a short labour. He was a small baby but his weight was within normal limits. For the first ten days following his discharge from hospital, midwives visited Ms M and nothing unusual was noted. The Health Visiting Service later noted the baby had a Mongolian Blue Spot but the documentation did not say where, what size or describe the appearance.[7]

25. On day ten, in line with usual practice, midwifery handed over responsibility for Baby F to the Health Visiting Service. Lack of capacity meant that there had been no ante-natal visit from Health Visiting; although a visit is considered best practice it is not uncommon and, as no particular concerns about Ms M had been identified, was not significant in the context of this Review.

26. Health Visiting became aware of some of Ms M's feelings and anxiety from the beginning of their contact. Over the first couple of visits Ms M reported :

    - An unplanned pregnancy
    - Low mood
    - Relationship tensions

[7] Mongolian Blue Spot is a type of birthmark that is present at birth or appears soon afterwards. They are very common in children of African, Middle Eastern, Mediterranean or Asian background. It is important to document them to prevent them being mis-diagnosed as bruising.

- Difficulty with sleeping
- Anxiety over bonding with the baby
- Problems with breast feeding the baby
- Not waking for the baby at night
- Lack of family support.

27. Ms M also shared with the Health Visiting service that she had had some difficulties and disruption in her childhood. These factors were indicators that Ms M was at risk of post-natal depression and in line with good practice; the Health Visitor used assessment tools, the Whooley Questions, and a Moods and Feelings Assessment to gain further information.

28. Health Visitors report that in general, their response to an assessment is primarily limited to "signposting" to services within the community and advised Ms M to self-refer to the Health Services' Counselling Programme. (The Health Visitor didn't know at this point that Ms M was attending work place counselling) This was despite Health Visitors reporting to this review that the waiting time for the counselling service is over a year "so there's not much point in referring."

29. The Health Visiting service also offered Ms M the MESCH service. The Maternal Early Childhood Sustained Home-visiting (MECSH) programme is an evidenced based, structured programme of intervention for vulnerable mothers which encompasses primary health care and can include more specialist services as required. In this case the MESCH programme was to include weekly visits for six weeks followed by fortnightly visits until the baby was 12 weeks old.

30. The planned weekly visits did not take place, partly because of staff holidays and partly because the Health Visitor did not prioritise this case, of a possible 7 visits only 3 took place; the case was not seen as high risk by the Health Visitor and therefore no "cover" was requested during her absence. Had more visits taken place it is possible that a more in depth understanding of the family might have been achieved.

31. The Service Specification for Health Visiting which sets out the standards expected indicates that a further Moods and Feelings assessment should take place after four visits in order to assess any change, this did not happen in this case; neither is there any evidence that Ms M was offered help with breast feeding.

Keeping a Focus on the Baby

32. The challenge of working with families when the parents have their own needs is always the risk of losing focus on the needs of the baby. When a mother has post-natal depression the

guidance makes many references to the effectiveness of a supportive partner, with two parents diagnosed with depression the potential impact on a baby's care is likely to be greater.

33. The focus of intervention with the family over the 12 weeks before Baby F's injuries were diagnosed was support for his parents. There is very little information in the records about the baby, his development and the nature of parental attachment. Baby F was only weighed by the Health Visitor twice in the 12 week period, partly because it is more practical and more usual for a baby to be taken to a local clinic for weighing. In this case the baby wasn't taken to the clinic and although he was a small baby, there were no obvious concerns about his weight. Had the baby been undressed and weighed at home this would have created an opportunity to observe the parents handling of the baby and observation of his physical well-being including signs of injury.

34. The Health Visiting Service works to full capacity and decisions have to be made about prioritising resources, visiting frequency and direct contact with babies and children. The learning here is that the Health Needs Assessment which highlighted a number of risk factors from both parents, including post-natal depression, appears to have had little impact on the quality of intervention. Although there is information about both parent's well-being, Ms M's not waking at night, problems with breast feeding and lack of family support, there is limited information about the impact of the parent's needs on the day to day care of the baby.

Learning Point:

- Assessing mothers is good practice, but the assessment has limited value if it does not inform a plan and intervention and if progress is not regularly reviewed.

- When parents have needs of their own there is a risk that focus on the child will be lost; weighing and observation of a baby provides a valuable opportunity to be alert to a baby's progress and any indications of concern.

Invisible Fathers

35. The Health Visiting Service's own review of this case indicates that Mr F was largely "invisible" to the service and the Health Visitors reported this is not unusual as fathers are often absent during visits. Yet in this case Mr F was observed to be carrying out much of the care of the baby, sleeping in the same room as Baby F as Ms M wasn't waking for him, feeding baby F and telling Health Visitors about his own feelings and low mood. Interestingly it was also Mr F who took Baby F to hospital on the two occasions he was seen there and who took him to nursery on several occasions.

36. Information on how to respond to post-natal depression in mothers commonly refers to the need for a supportive partner. Apart from one reference to his handing the baby sensitively, there was no assessment by the Health Visiting Service of Mr F's own "moods or feelings" and how this might impact on his parenting capacity or ability to be the supportive partner. Mr F was diagnosed with post-natal depression a few days after Ms M, when Baby F was 8 weeks old.

37. Although it started well, the overall quality of work carried out by the Health Visiting Service appears to have been superficial. The recognition of potentially significant factors known to affect parenting and increase risk appears to have had little impact on the work undertaken with this family.

Learning Points:

- It is important to seek active engagement with *both* parents with a view to assessing their mental health and ability to be a supportive partner. This is especially important if either or both parents are diagnosed with post-natal depression.

- Opportunities to speak with parents alone, particularly when one has a mental health problem, are invaluable in contributing to the assessment of the impact of parental health on the care of a baby.

The Importance of Supervision

38. The Health Visiting Service has a clear and comprehensive supervision policy which says that all safeguarding cases must be brought to supervision and any other cases, which may not be

regarded as safeguarding but may be complex, can also be discussed. The Health Visitor in this case was relatively inexperienced and did not consider this case as one which needed to be discussed in supervision.

39. The Health Visiting Service has reviewed their practice and concluded this case should have been brought to supervision. The service is reviewing its supervision policy to emphasise the importance of recognising the complexities of any parental mental health issues and with particular attention to how MESCH cases should be overseen.

Learning Points:

- Knowing which cases to bring to supervision is an important skill. For less experienced staff, supervisors need to be vigilant to ensure the most vulnerable families are discussed, and assessments and interventions are carried out as planned.

Consideration for the PSCB

- The PSCB should seek assurance that the individual agency learning from this case and other learning which has emerged as part of the review, has been formally identified and addressed by the relevant agency.

The Family's Contact with GPs

40. Ms M had four contacts with the GP practice in the period between Baby F's birth and his head injury; staff at the practice, were aware of Ms M's anxiety and she was formally diagnosed with post-natal depression at the beginning of September, about two weeks before the baby's head injury.

    At the same time as the depression diagnosis, the GP had tried to contact the Health Visitor to discuss Ms M's mental health, problems with availability meant they weren't able to speak to one another and the GP's receptionist passed on a message to the Health Visitor which led to a "listening visit" from the Health Visitor. [8]

41. The contact the surgery had with Ms M gave them no reason to consider that Baby F was at risk of harm.

[8] Listening Visits: An Evaluation of the Effectiveness and Acceptability of a Home-based Depression Treatment, Segre et al, Psychotherapy Research Journal, Nov 2010

Diagnosing Post-Natal Depression in Fathers

42. Mr F was registered at a different practice from Baby F and Ms M and it was Mr F's GP who confirmed his diagnosis of post-natal depression. This was an unusual event for the GP who had not come across post-natal depression in fathers before. The consultation took place on the telephone as there were no appointments available that day; this is common practice in the area and is an essential part of coping with demand, but meant the GP did not see Mr F. Also notable was that Mr F came across as a well educated, thoughtful man who had researched the symptoms of post-natal depression and appeared to be looking to the GP for confirmation of his diagnosis and for treatment.

43. The GP was robust in her questioning, asking the same questions of Mr F as Ms M's GP had asked of her, about thoughts of harming the baby, about thoughts of self-harm and exploring what might prevent such actions. Although Mr F acknowledged he had had thoughts of both, he reassured the GP that he was confident he would not act on his feelings. The GP also asked about Ms M and was told she too was suffering with post-natal depression.

44. The GP was reassured by Mr F's responses and agreed to prescribe an anti-depressant medication, the GP also discussed counselling and Mr F said he had already self-referred. Unable to make the first counselling appointment offered, he was offered a later appointment which was due to take place just after Baby F's head injury occurred.

Was this is a missed Opportunity?

45. The response to Mr F appears to have been appropriate. On reflection, the GP was reassured by Mr F's knowledge, confidence, his measured responses to the questions asked and that he was being pro-active and said he wanted to be supportive to his partner and family.

46. Had the consultation been with a mother with post-natal depression, the GP reports that this might have been more probing and might possibly have arranged a follow up appointment to see the parent and baby together; the father's GP was disadvantaged because the baby was registered at a different practice and the GP didn't have access to the baby's records which would have provided extra information about the baby including information about the previous hospital visits. Although this might not have made a difference to the outcome of the consultation, it would have provided a bigger picture of family life.

47. The lost opportunity here was not sharing the information from this consultation with another agency. The GP, on reflection, takes the view that it is unlikely that Children's Social Care would see this as meeting the threshold for action (although the GP also thinks Mr F would have agreed to a referral) but has concluded that a conversation with Baby F's Health Visitor would have been appropriate.

48. The information about Mr F's mental health may not have met the threshold for intervention from Children's Social Care; it is also unlikely that even if a conversation with another agency had taken place at this time, the outcome for Baby F would have been different. The GP's information about Mr F was only a part of the jigsaw which had not yet been put together however, the need for effective information sharing remains a vital part of safeguarding practice.

Learning Points:

- When *both* parents are diagnosed with post-natal depression the potential impact on the care of a vulnerable baby is potentially greater; it is important to keep the child in mind when deciding what action to take.

- When a health professional has information relevant to the care of a vulnerable baby, consideration must be given about how this can be shared and with whom. This will contribute to the development of a holistic picture of family functioning and any risk to children.

- All agencies need to be alert to the risk that articulate, well informed and confident parents can be falsely reassuring in their self-reporting.

UNUSUAL MEDICAL PRESENTATIONS IN NON-MOBLE BABIES AND CHILDREN

49. Sidebotham et al in their paper, Pathways to Harm, Pathways to Protection state:

> *"The high number of serious case reviews conducted with regard to babies under one year of age reflects the intrinsic vulnerability of the youngest babies who are dependent on the parents for care and survival."* [9]

50. Injuries in babies and infants who are not crawling, cruising or walking (non-mobile) are rare and there is a wealth of research about their significance as potential indicators of child abuse. For example, the NICE guideline "When to Suspect Child Maltreatment"[10] uses the terms "injuries and presentations" and prompts health practitioners to consider the possibility of maltreatment in forming a diagnosis, or as part of differential diagnosis.[11]

51. The Guidance states:

> *"If an alerting feature or considering child maltreatment prompts a healthcare professional to suspect child maltreatment they should refer the child or young person to children's social care, following Local Safeguarding Children Board procedures."*

52. For all agencies working with children and families, the Plymouth Safeguarding Children Board practice guidance can be found as part of the South West Area Child Protection Procedures, [12] the "Bruising and Injuries in Non-mobile Children Protocol."[13] The procedures are clear that:

> *"due to the significant risk of abusive injury ALL non mobile babies with an injury or bruising should be considered as a potential indictor of abuse unless evidenced otherwise by health professionals."* [*sic]*

It also says *"all injuries, however minor, are a cause for concern;" "all bruising on non mobile babies must prompt a referral to social care."*

53. In addition to the Child Protection Procedures, Safeguarding Boards often have specific guidance for practitioners about injuries and medical presentations in non-mobile children. (The term non-mobile is used in order to include older children who may be non-mobile because of disability) The Plymouth Safeguarding Children Board's guidance "Bruising on pre-

[9] Sidebotham et al, Pathways to Harm, Pathways to Protection, a triennial analysis of Serious Case Reviews 2011 to 2014, May 2016
[10] See: http://guidance.nice.org.uk/CG89
[11] A differential diagnosis is considering which of several possibilities might be producing the symptoms
[12] South West Child Protection Procedures, 2017
[13] Plymouth Safeguarding Children Board Guidance Document Bruising on pre-mobile babies, Guidance on the detection and management on bruising in pre-mobile babies, 2014

mobile babies, Guidance on the detection and management on bruising in pre-mobile babies.... Babies don't bruise, break or bleed" can be found on their website.
The guidance sets out what action is to be taken if a pre-mobile baby found to have a bruise.

Sentinel Injuries

54. Studies about child deaths from non-accidental injuries show that these children often have a history of minor injuries prior to a very serious injury or death. Often this recognition comes later, with the findings of a severe or catastrophic non-accidental injury. In one study these injuries were present in 25% of children subsequently diagnosed as abused.[14] These minor injuries in babies are described as sentinel events or sentinel injuries. They are defined as minor inflicted injuries/physical signs that are presented to physicians *before* the recognition that the child has been abused.

55. In this case Baby F was seen twice at the Emergency Department of the local hospital, once when he was 5 weeks old and then again when he was 9 weeks old. Baby F was not bruised but he did have unusual presentations which were seen before his catastrophic head injury.

First Presentation

56. At the first hospital visit in August 2016, Baby F was noted to have a range of symptoms including his father reporting that the baby had been bleeding in his mouth; this was seen by the doctor as blood in sick on the baby's bib. The other symptoms the baby presented with included having been hot, unsettled and irritable; it was these symptoms which led the examining doctor in the Emergency Department to consider sepsis as a possible diagnosis; consequently Baby F was promptly transferred to the paediatric department and admitted for tests to exclude this potentially life threatening illness.

57. In the course of needing to assess and treat a potentially very serious illness, the presence of the blood in the mouth was overlooked. A note was made on the baby's record but this information was not considered significant by the doctors who examined the baby. In the context of possible sepsis, the bleeding appeared trivial and there was no exploration of the possible cause.

58. Bleeding from any orifice in an infant is very rare and in the absence of an underlying medical cause, can be an indicator of abuse.[15] Oro-nasal bleeding (bleeding from the mouth and /or nose) without an obvious medical cause is listed as a "red flag" presentation, and the hospital has issued a care pathway to be followed by medical practitioners, the "Management of a

[14] Sheets LK et al Paediatrics 2013: 131(4)
[15] McIntosh N, Mok JY, Margerison A Epidemiology of oro-nasal haemorrhage in the first 2 years of life: implications for Child Protection. Paediatrics 2007; 120(5):1074-8

Child under 12 months referred with Bleeding from Nose or Mouth."[16] The pathway indicates possible diagnoses and says that consideration should be given to the possibility of Child Protection concerns.

59. The protocol was not followed in this case. Had Baby's F's presentations been "red flagged" the hospital's safeguarding team would have been advised, the facts noted and proper consideration given to the possibility of risk of harm and if any further action was required.

60. However it is interesting to note that the blood on the bib was included in the discharge summary sent from the paediatric department to the GP practice and the Health Visiting Service. The information was added to the Health Visiting record 10 days later, the delay said to be caused by resource issues. There is no evidence that the Health Visitor saw the information or discussed the hospital visit with the parents. The information was not included in the chronology of the Baby's GP practice; the GPs appear to have been unaware of the incident.

    (See section on Effective Communication)

Second Presentation

61. The second visit to the Emergency Department took place four weeks later, when Baby F was 9 weeks old, and also involved an unusual presentation.

62. Mr F took Baby F to the Emergency Department reporting that the baby had recently been immunised and was upset and irritable. Also noted on his record was the presence of "red spots" in the baby's eyes. These were described differently in various hospital records and in subsequent conversations with medical practitioners as part of this review, as "haemorrhagic spots on the eyes," "red spots on his eyes" "blood spots on the eyes" and by Baby F's GP, who saw the Baby 2 days after the hospital visit, as "sub-conjunctival haemorrhages."

63. Sub-conjunctival haemorrhages are caused when the blood vessels on the surface of the eye are broken and, like bleeding in the mouth, whilst common in adults, are rare in babies. Where it does occur there is sometimes a clear link with another health problem, for example whooping cough; if there is no obvious explanation, sub-conjunctival haemorrhages can be an indicator of child abuse.

64. An example from the literature states:

    "sub-conjunctival haemorrhages in infants and children can be a finding after non-accidental trauma. We describe 14 children with sub-conjunctival haemorrhages on

[16] Taken from: Epidemiology of oro-nasal haemorrhaging and suffocation in infants admitted to hospital in Scotland over 10 years. Arch Disease in Childhood, 2010

physical examination who were subsequently diagnosed by a child protection team with physical abuse. Although infrequent, sub-conjunctival haemorrhage may be related to abuse. Non-accidental trauma should be on the differential diagnosis of sub-conjunctival haemorrhage in children, and consultation with a child abuse paediatrics specialist should be considered."[17]

65. In this case, Baby F was seen and examined by a junior doctor who concentrated on the fact of the recent immunisations and quickly reached the view there was nothing of particular concern. In a similar way to the first presentation, it was the mention, by Mr F, of the possible reaction to the immunisation which distracted the doctor who examined Baby F away from considering the possible significance of the "spots on the eyes."

66. Any child who is seen in the Emergency Department has to be "signed off" by a senior doctor before they can be discharged. In this case the "signing off" involved the junior doctor giving a brief verbal report to the senior doctor. It is not unusual in this busy emergency department, that a child is not actually seen by the senior doctor signing off and Baby F was not seen. The junior doctor was not available to be interviewed as part of this review, but is said to have reported the baby as having a reaction to his immunisations with a recommendation that he be discharged home and his father given advice about management. The "haemorrhagic spots on the eyes" were reported to have been mentioned, but the senior doctor did not think about the possible significance and therefore no consideration was given to whether any further action or referral to paediatrics was necessary.

67. It would appear that the reasons for the oversight were:

    - The use of the term "spots on the eyes" which does not accurately describe the presentation
    - The concentration on the recent immunisations and the view that the symptoms Baby F was exhibiting related to that, leading to the information which did not fit a hypothesis being disregarded
    - The volume of work at this busy emergency department which means babies are not routinely seen by senior doctors as part of the signing off process

68. These findings resonate with the learning summarised in the NSPCC's publication, "Paediatrics and accident and emergency: learning from case reviews" which says "*Within medical teams there can be poor communication and escalation of concerns. Some Reviews uncovered evidence of doctors over-estimating how well they had briefed doctors coming on duty*[18]."

15 Sub-conjunctival Haemorrhages in Infants and Children: A Sign of Non accidental Trauma, Paediatric emergency care 29(2):222-6 · February 2013, Catherine A Deridder et al

[18] Paediatrics and accident and emergency :learning from case reviews, Summary of risk factors and learning for improved practice for the health sector, NSPCC, May 2015

69. Also relevant is that the senior doctor was not aware that Baby F had been seen in the emergency department four weeks earlier. The medical practitioners at the Emergency Department reported that "99% of the time no notes are available, you have to rely on what parents tell you." This understanding is not accurate as patient notes are available to be viewed on the computer system and administrative staff make a note on a child's record of the number of previous attendances.

70. Another factor which was considered by staff to have hindered recognition was a change of name. The first time Baby F attended the emergency department he was booked in under his mother's family name, on the second occasion he was using his father's family name. This is not unusual for new-born babies however all patients have a unique NHS number which avoids the risk of relying purely on names. This case highlights the need to both seek out patient records and to be attentive to NHS numbers as well as patient names.

71. Had the senior doctor known about the earlier hospital visit, this would have provided another opportunity for consideration of the risk factors.

72. Sub-conjunctival haemorrhage has recently been reinstated on the hospital protocol as a "red flag" injury which should be referred to the safeguarding team. The minimising of the potential relevance of Baby F's "spots on the eyes" meant an important opportunity was lost both for proper consideration, diagnosis and "red flagging" and later by leaving the information off the discharge summary, there was no opportunity for a second opinion or follow up once the baby was back in the community.

Learning Points:

- All practitioners need to be mindful about the importance of using clear and accurate language, particularly when describing unusual presentations which are open to interpretation.

- Practitioners should ensure they consider *all* of a child's symptoms and signs when formulating the differential diagnosis at presentation in order to avoid downplaying or ignoring those commonly seen in unwell children but which may be indicative of abuse.

- The presence of a number of apparently minor injuries to a baby can be considered Sentinel Injuries and may be an indication that the child is at risk of harm.

- Knowing if and when a baby has attended the Emergency Department is important in alerting health professionals to the potential significance of apparently minor injuries. Information systems must be accessible and fit for purpose.

Consideration for the PSCB

73. Although "bruising" was not a feature of Baby F's presentation at hospital, the studies on injuries and presentations in non-mobile babies and children demonstrate that the principles behind the protocol apply to all injuries including bleeding and other unusual medical presentations. The phrase on the website, "babies don't bruise or bleed" could usefully be developed into a more comprehensive protocol which makes specific reference to other types of injuries and presentations. See for example, Western Bay Safeguarding Children Board, Multi-Agency Policy for Minor Injuries in Babies, 2015, which specifically mentions oro-nasal bleeding and sub-conjunctival haemorrhaging and Bristol Safeguarding Children Board, Multi-Agency Guidance for Injuries in NON-MOBILE Babies, 2015.

74. The challenge for the PSCB is not new, in 2010 the death of a four week old baby, known as Child E, led the Board to commission a Serious Case Review. Although this child died seven years ago, it is notable that there are some issues which impacted on that case which remain unresolved; namely the impact of a mother and father being registered at different GPs and the guidance in relation to unusual presentations, in that case a "red mark."

75. The report points out:

"the need for GPs to be aware of the significance of information they hold in respect of parenting capacity and in this case sharing of information was affected by the parents

being registered at different practices. Developing effective information sharing pathways in such circumstances is therefore crucial ..." SCR, Child E, 2010

The PSCB should satisfy itself that their guidance on the detection and management of bruising, injuries and unusual medical presentations in non-mobile babies and children is clear and comprehensive and that is it understood and able to be applied consistently by all agencies.

Effective Communication

76. There are a number of examples from this review where communication was not effective. The previous section of the report describes the need for accurate language when describing presentations; this is particularly important when examining babies.

77. In addition to communication within organisations, there were a number of occasions in this case where poor communication between agencies impacted on practice.

78. Although Baby F's unusual presentations at the Emergency Department did not trigger a safeguarding alert, had the information been properly communicated to the GP and Health Visiting Service, this would have created an opportunity for a second opinion on the nature of the medical presentations and also to consider the implications within a broader knowledge of the family. Health Visitors are particularly well placed to have an overview of the issues affecting different family members.

Discharge Summaries

79. When a baby is seen in hospital, discharge summaries are sent to the GP and Health Visiting Service. If the baby is seen by a paediatrician, as was the case in baby F's first admission, the discharge summary is typically a three page document detailing the presenting symptoms, treatment carried out and any follow up required. If the baby is seen in the emergency department and doesn't need to see a paediatrician, as in the second hospital visit, the discharge summary is shorter and uses tick box computer generated menus with a space for the doctor to add a note for the GP if necessary.

80. After the first hospital visit the "blood coming out of the baby's mouth (in his sick)" was included in the discharge summary but the summary was not seen by either the GP or health visiting service. This meant that a potentially valuable opportunity for a second consideration of the bleeding was lost.

81. The reason the information was not seen lies within the systems for receiving information and ensuring it is seen by the relevant people. For the Health Visiting Service, at the time of these events, information was placed on the Baby's file as an administrative action, for the Health

Visitor to know it was there, required checking the file before every visit. This didn't happen in this case. This cumbersome process has since been changed and now all communications are passed to the lead Health Visitor who is required to note a response to the information, pro-actively passing it on to the allocated Health Visitor when appropriate.

82. A similar system is in place for the GPs where information from the hospital is placed on the patient file, it is reviewed by a duty GP who assesses the significance and decides if any action is required. In this case the information about the bleeding was either not seen, or not seen as significant, and the GPs remained unaware of it.

83. After Baby F's second hospital visit the discharge summary did not mention the "haemorrhagic spots in the eyes" and therefore the Health Visitors were not aware of it and there is no mention in their records that it was observed by the Health Visitor.

84. However Baby F's GP was aware of the presentation because Mr F took the baby to the surgery a few days after the hospital admission and discussed it with the GP. The GP records note that Baby F had "small bilateral sub-conjunctival haemorrhaging." The GP was alert to the possibility that this may have been caused by a non-accidental injury and was robust in questioning Mr F about the presentation. The GP examined Baby F, weighed him and saw nothing which caused alarm; the GP was re-assured by Mr F reporting that the baby had been seen by doctors at the Emergency Department who, Mr F said, had been satisfied that the bleeding was caused by the baby "straining." (to evacuate his bowels) This was not mentioned in any of the hospital records but after a lengthy consultation, the GP was satisfied that no further action was necessary. The GP assumed that the ED has acted robustly and would have been aware of the possible implications of sub-conjunctival haemorrhaging in a baby. Checking back with the Emergency Department would have created the possibility of further consideration about whether any action needed to be taken.

Learning Point:

- Sub-conjunctival haemorrhaging in babies can be an indicator of child abuse. Relying on parents self-reporting runs the risk of being falsely re-assured. For all agencies it is important to remember that parents can be misleading when giving an account of injuries and professionals need to retain an open mind and use their own professional judgement in deciding whether or not to take action.

KNOWLEDGE AND UNDERSTANDING OF THE CHILD PROTECTION PROCEDURES AND THRESHOLDS FOR REFERRAL

85. The expectation of the Plymouth Safeguarding Children Board is that all agencies who worked with this family, adults or children's services, would be familiar with the South West Child Protection Procedures. As part of learning and disseminating knowledge of the procedures, staff from all the agencies are invited and expected to attend basic Child Protection training. All the agencies are expected to be able to access a Safeguarding Advisor who is expected to have a detailed understanding of the procedures and the principles which underpin them.

86. There were two occasions during the period of this review where the Child Protection procedures should have been followed but were not.

87. A few days before Baby F was admitted to hospital with his head injury, he was observed by nursery staff to have a small mark on his cheek which may, or may not, have been a bruise. The mark was described by staff during the process of this review as being about 1 × ½ cm and showed as a slight discoloration of the baby's skin. Because of the colour of the Baby F's skin, it was difficult for the staff to decide if this was a bruise or a skin pigmentation. The staff group looking after Baby F briefly discussed the mark but reached no decision and no action was taken.

88. The staff should have referred their concern to their manager, who as Safeguarding Advisor, would have taken the decision whether or not to refer to Children's Social Care. It is impossible to know whether a referral at this stage would have changed the outcome for Baby F in any way as the mark may not have been a bruise. However, in response to this case, the nursery have carried out an internal review and all staff have been reminded about the protocol for action to be taken if bruising on a non-mobile baby is observed or suspected. The nursery has also reviewed their recording practice in order to ensure all pre-existing birth marks are noted. This case has been a stark reminder to nursery staff that some children are subjected to child abuse and they report that they are more sensitised to the possibility and more observant of the babies in their care.

Learning Point:

- It can be difficult to distinguish between bruising and skin pigmentation on babies, any marks on pre-mobile babies which have not been previously documented, should be discussed with the agency's safeguarding lead and the Child Protection Procedures followed.

ADULT SERVICES WORKING WITH PARENTS AND THEIR RESPONSES TO SAFEGUARDING CONCERNS

89. It is not uncommon in Serious Case Reviews for comments to be made about the need for services for adults to be mindful about the implications of parental behaviours and/or mental health on children. In this case, during July, August and September, Ms M was receiving counselling provided by a work place service.

90. In that setting it was unusual for counsellor's clients to be parents; the counsellor was not very experienced and had no knowledge of Child Protection, the South West Child Protection Procedures or how to respond if there were any concerns about a child.

91. The agency concerned, despite being a significant and well established part of the local education system, sometimes working with parents and sometimes working with older children (16+) did not have a Child Protection policy, the counselling department had no knowledge or understanding of the Child Protection Procedures and the agency did not have a named Safeguarding Advisor. All of this meant they were ill equipped to manage concerns about possible risk or harm to children.

92. It became obvious at the start of Ms M's therapy that, as well as her current problems, Ms M had some complex historical issues relating to her own childhood. The counselling agency acknowledges that in hindsight, this case should have been allocated to a more experienced worker.

93. As the sessions continued Ms M appears to have freely shared information about her home life and the stresses of parenting. To her credit, the counsellor sought advice from a senior colleague who suggested some lines of enquiry about Ms M's safety and encouraged the counsellor to liaise with Ms M's GP and Health Visitor in order to make sure she was getting their support. In the event, this never happened and the counsellor left it to Ms M to pursue this action herself.

94. Earlier on the same day that Baby F was admitted to hospital with his head injury, Ms M had a counselling session; she told the counsellor that Baby F's father had accidentally banged the baby's head on a cupboard. The counsellor discussed the matter with a senior colleague who asked about the counsellor's view of the risk to Baby F. The supervisor appeared to have been re-assured by the counsellor's response; this was thoughtful and considered and included reference to Ms M's improved demeanour and response to an assessment tool which indicted she was feeling less anxious than previously. As a result no further action was taken.

95. The counsellor and/or the supervisor should have taken immediate advice from a safeguarding advisor who should have referred the matter to Children's Social Care without delay.

96. To their credit the agency concerned has recognised the shortfalls in their Child Protection Practice and have devised a detailed action plan to address the deficits. The plan includes actions for individuals, for example training, and for the agency the recruitment of a Safeguarding Advisor. The agency is also seeking to develop links with the Safeguarding Board.

Learning Point:

- All agencies have a responsibility for safeguarding children. Agencies working with adults who are parents must always keep the child in mind and be clear about the limits of confidentiality and when there is a need to take action.

Consideration for the PSCB

- The PSCB should assure itself that associate counsellors working for the counselling service in this case are familiar with and follow BACP guidelines with regard to safeguarding children.

SUMMARY OF LEARNING

1. Identification and Response to Post-Natal Depression

a) Fathers can experience post-natal depression, the signs and symptoms are similar to those of mothers and the potential effects on children are equally serious.

b) Assessing mothers is good practice, but the assessment has limited value if it does not inform a plan and intervention and if progress is not regularly reviewed.

c) When parents have needs of their own there is a risk that focus on the child will be lost; weighing and observation of a baby provides a valuable opportunity to be alert to a baby's progress and any indications of concern.

d) It is important to seek active engagement with both parents with a view to assessing their mental health and ability to be a supportive partner. This is especially important if either or both parents are diagnosed with post-natal depression.

e) Knowing which cases to bring to supervision is an important skill. For less experienced staff, supervisors need to be vigilant to ensure the most vulnerable families are discussed, and assessments and interventions are carried out as planned.

f) When both parents are diagnosed with post-natal depression the impact on the care of a vulnerable baby is potentially greater; it is important to keep the child in mind when deciding what action to take.

g) When a health professional has information relevant to the care of a vulnerable baby, consideration must be given about how this can be shared and with whom. This will contribute to the development of a holistic picture of family functioning and any risk to children.

h) All agencies need to be alert to the risk that articulate, well informed and confident parents can be falsely reassuring when self-reporting.

2. Response to Unusual Medical Presentations in Pre-Mobile Babies

a) All practitioners need to be mindful about the importance of using clear and accurate language, particularly when describing unusual presentations which are open to interpretation.

b) Practitioners should ensure they consider all a child's symptoms and signs when formulating the differential diagnosis at presentation in order to avoid downplaying or ignoring those commonly seen in unwell children but which may be indicative of abuse.

c) The presence of a number of apparently minor injuries to a baby can be considered Sentinel Injuries and may be an indication that the child is at risk of harm.

d) Knowing if and when a baby has attended the Emergency Department is important in alerting health professionals to the potential significance of apparently minor injuries. Information systems must be accessible and fit for purpose.

e) Sub-conjunctival haemorrhaging in babies can be an indicator of child abuse. Relying on parents self-reporting runs the risk of being falsely re-assured. For all agencies it is important to remember that parents can be misleading when giving an account of injuries and professionals need to retain an open mind and use their own professional judgement in deciding whether or not to take action.

f) Knowledge and Understanding of the Child Protection Procedures and Thresholds for Referral

3. Knowledge and Understanding of the Child Protection Procedures and Thresholds for Referral

a) It can be difficult to distinguish between bruising and skin pigmentation on babies, any marks on pre-mobile babies, which have not been previously explained and documented, should be discussed with the agency's safeguarding lead and the Child Protection Procedures followed.

4. Adult Services working with Parents and their Responses to Safeguarding Concerns

a) All agencies have a responsibility for safeguarding children. Agencies working with adults who are parents must always keep the child in mind and be clear about the limits of confidentiality and when there is a need to take action.

CONSIDERATIONS FOR THE PSCB

a) The PSCB should seek assurance that the individual agency learning from this case and other learning which has emerged as part of the review, has been formally identified and addressed by the relevant agency.

b) The PSCB should satisfy itself that their guidance on the detection and management of bruising, injuries and unusual medical presentations in non-mobile babies and children is clear and comprehensive and that it is understood and able to be applied consistently by all agencies.

c) The PSCB should assure itself that associate counsellors working for the counselling service in this case are familiar with and follow BACP guidelines with regard safeguarding children.

APPENDICES

A. List of Practitioners involved with Baby F and his Family

Health Visiting
General Practitioners
Counselling Service
Midwifery
Emergency Department and Paediatric Department, local hospital
Nursery

B. Members of the Serious Case Review Group

DCI, Public Protection Unit, Devon & Cornwall Police, Chairman
Head of Safeguarding (Children and Adults), NEW Devon CCG
Joint Acting Principal Educational Psychologist, Plymouth City Council
Head of Safeguarding, Children, Young People and Families, Plymouth City Council
Designated Doctor, Safeguarding Children, NEW Devon CCG