PLYMOUTH SAFEGUARDING CHILDREN BOARD

Serious Case Review

"Harry"

CN 026

Independent reviewer

Dr Deborah Stalker FRCPCH

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A Introduction

1 Events leading to this review

1.1 In May 2018 a four month old baby had been found not breathing and unresponsive at his home. He was resuscitated by paramedics and subsequently required intensive life support in a Paediatric Intensive Care Unit.

1.2 He was found to have sustained severe and irreversible brain damage; continued intensive life support was considered to be futile and therefore palliative care was carried out until his death.

1.3 Routine investigations as part of the Child Death Review process[1] subsequently identified multiple lower limb fractures.

1.4 A forensic post – mortem was carried out with further investigations revealing the fractures were of different ages and of a type strongly associated with non – accidental injury.

1.5 For the purposes of anonymity the infant will be referred to as Harry.

2 Decision to undertake a review

2.1 The Serious Case Review subgroup carried out a review of the circumstances surrounding Harry's death on behalf of Plymouth Safeguarding Children Board. It was determined that the case fitted the criteria for a Serious Case Review under Working Together 2015[1].

2.2 This states that under Regulation 5 of the LSCB Regulations 2006, the LSCB must undertake a review where abuse or neglect are suspected and the child has died or there are concerns about the ways agencies have worked together in safeguarding the welfare of the child.

2.3 At the time of this decision, Plymouth Safeguarding Children Board had not made the transition under new arrangements to Working Together 2018 hence this case review is carried out under the procedures set out in Working Together 2015.

2.4 The Serious Case Review subgroup convened a multiagency panel to oversee the process and quality assure the output of the review.

2.5 Terms of reference were constructed and can be seen at **Appendix 1**.

3 Method

3.1 An independent reviewer was appointed[2] and the process was overseen by the Serious Case Review subgroup consisting of senior managers and practitioners.

3.2 An appreciative enquiry approach was agreed. Agencies produced a chronology of their involvement with the family and a reflective summary of their interactions with the family.

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[1] Working together to safeguard children 2015 www.gov.uk

[2] Dr Deborah Stalker is a retired Consultant Paediatrician with broad experience in clinical safeguarding and strategic work at Local Safeguarding Board level.

3.3 They were asked to identify areas of good practice and also where practice could be improved both within their agency and in partnership working.

3.4 A practitioners' learning event was held, led by the independent reviewer, to confirm facts, clarify actions, promote further analysis (particularly in interagency working) and identify any gaps in learning which still needed to be addressed.

3.5 Focus was not simply on how individual agencies had managed this case but also on the context within which practitioners were working, the wider issues of application of protocols and procedures, resource and other systemic limitations.

3.6 The following agencies were involved in this case analysis:

- Ambulance services
- Primary Care – General Practitioner (GP)
- Secondary Care (Midwifery, Paediatrics, Neonatal Outreach Service, Neonatal Intensive Care Unit)
- Community Midwifery
- Children's Social Care
- Health Visiting
- Police
- Care of the next infant (CONI)
- Barnardo's

3.7 The following agencies were represented at the practitioners' learning event:

- General Practitioner
- Secondary Care (Consultant Paediatrician)
- Community Midwives
- Health Visiting team
- Children's Social Care
- Headteacher (for Harry's sibling)
- Police

3.8 At the practitioner event the risk of hindsight bias was emphasised.

3.9 The case summary in section 7 below is based on information submitted by agencies in their chronologies, discussion at the practitioner event and telephone interviews of those who were unable to attend the practitioner event.

4 Scope of review

4.1 The review was to cover the period of mother's pregnancy with Harry until the time of his death.

5 Family structure and contribution to the review

5.1 For the purposes of anonymity the family members are referred to as follows:

Harry	-	Subject of this review
Ms H	-	Mother of Harry
Mr H	-	Father of Harry
Susan	-	Half sibling of Harry (daughter of Ms H)
John	-	Half sibling of Harry (son of Mr H)

5.2 Harry is the first child of Ms H and Mr H.

5.3 Ms H has a school-aged child from a previous relationship. This child (Susan) was living with Ms H, Mr H and H.

5.4 Mr H also has a child from a previous relationship who lives with his grandparents under a Special Guardianship Order.

5.5 The views of the family can provide useful information to aid case analysis and inform learning and practice.

5.6 At the time of this review, there were parallel family court proceedings which may lead to criminal charges. Direct involvement of the immediate family was therefore not advised at the time of this review.

5.7 Due to his age Harry's voice could not be heard directly.

5.8 Susan was not the subject of this review but her lived experience in sharing the family home with Harry, her mother and Harry's father can be inferred from the descriptions in the case summary below.

5.9 In the process of this review, Susan's voice was heard through reports of conversations with her by her social worker. When asked about home life, Susan's responses were short and gave limited information about how she felt life was like for her in the family home.

6 Summary of relevant information prior to timescale of review

6.1 Ms H had been subject of a child protection plan as a young child (category – emotional harm).

6.2 As an older child, concerns were raised regarding her mental health and self-harming behaviour.

6.3 At 15 years of age she fell pregnant in circumstances which made bonding with her child challenging.

7 Case summary

7.1 Pre - birth events

7.2 At the midwifery booking appointment, Ms H was identified as being vulnerable because of mental health concerns and reported difficulties bonding with her previous child.

7.3 A referral was made to Children's Social Care and information regarding the pregnancy and the identified vulnerabilities were passed to the Health Visiting service. This is good practice.

7.4 Children's Social Care completed their assessment with the outcome that Harry and Susan should be supported under a Child in Need Plan. It was also suggested that Ms H be referred to the Perinatal Mental Health Team by her midwife. This did not occur as she did not meet the threshold for this service.

7.5 Whilst Ms H was pregnant, a Child in Need home visit was carried out by the Social Worker who noted a strong smell of smoke in the home. It was planned to complete a Family Support Worker Assessment however Harry's premature birth (32 weeks' gestation) intervened and prevented this.

7.6 Post-natal events

7.7 A further Child in Need home visit took place whilst Harry was an inpatient on the Neonatal Unit.

7.8 This identified that the house, carpets and furniture were dirty along with a rubbish – strewn garden. The kitchen was dirty and the house was noted to be very cold. Inappropriate (adult) DVDs were stored in Susan's room.

7.9 The parents were tasked with cleaning, clearing and sorting these concerns which they did promptly. However, this was not maintained.

7.10 A further joint Social Work visit with the Health Visitor was planned and took place prior to Harry's discharge from the Neonatal Unit.

7.11 At this visit both maternal and paternal mental health were discussed. It was established that neither were receiving help from mental health services. Mother was not on medication at that point. The house remained cold, unclean and smelt of smoke according to the Health Visitor whilst the Social Worker described it as "*tidier and cleaner*".

7.12 A Discharge Planning/Child in Need meeting was held. Information was shared regarding follow–up and monitoring plans following discharge. Mum reported she had started on antidepressants and the house was reported (by parents) to be clean and tidy.

7.13 It was noted by neonatal staff that his parents had not visited daily and did not always spend a significant amount of time with Harry. It is unclear whether the implications of this were fully explored at the discharge planning meeting.

7.14 A family history of sudden infant death syndrome ("cot death") was reported so Harry was supplied with an apnoea monitor (from the neonatal unit) and referred into the CONI programme[3]. The CONI Coordinator was not invited to the discharge planning meeting.

[3] CONI = Care of next infant – an intensive visiting and support programme for families with a history of Sudden Infant Death Syndrome (SIDS also colloquially known as cot death). An apnoea monitor may also be used which detects when an infant stops breathing.

7.15 He was discharged home at two weeks of age (chronological age). Please note because of his prematurity he was still, at this point, six weeks preterm.

7.16 The neonatal outreach nurse visited on the afternoon following the day of discharge. She found Harry extremely unwell and called an emergency ambulance. Although he had not fed since his early morning feed, his parents had not recognised that he was so poorly. He required intensive life support for several days and was subsequently diagnosed with septicaemia and meningitis (a severe and life threatening infection). He remained in hospital for two weeks.

7.17 Following successful treatment, he was discharged home with plans for frequent visits from the neonatal outreach team and the Health Visitor. Following a meeting with both parents and the Health Visitor, he was discharged by the neonatal outreach team. He was reported as thriving and making good progress.

7.18 The Child in Need plan was put in place prior to his discharge from the neonatal unit. A review meeting was held one month later (6 weeks chronological age, corrected age - term minus 2 weeks) at which the Child in Need plan was discontinued.

7.19 At a corrected age of 9 days, a Family Support Worker had visited Harry at home and noticed he had a red eye. She reported this to Children's Social Care.

7.20 She also asked Ms H to contact the GP or Health Visitor regarding his eye and followed this up by ringing the family the following day to check that they had sought medical attention for Harry. Ms H told the Family Support Worker that they had an appointment with the GP that afternoon for his 6 - 8 week check.

7.21 The Family Support Worker also reported this red eye to the Health Visitor by e mail. A subsequent phone call from the Health Visitor on the day of the GP appointment reassured the Family Support Worker that the Health Visitor would speak to the GP and follow up with Ms H. The Family Support Worker informed Ms H of this plan.

7.22 The parent's subsequently disengaged from this service and the Family Support Worker did not visit further. She informed the Health Visitor of this. Children's Social Care had already closed the case at this point.

7.23 Harry was seen for a routine 6 – 8 week check by his GP at a corrected age of 10 days. No concerns were noted. The examination was said to be normal. It is reported that concerns about Harry's eye were not mentioned during this visit.

7.24 Following this examination Mr H rang the Health Visitor to report Harry's weight gain but also stated that his bloodshot eye was fading and that the GP had said that this was due to Harry straining at stool.

7.25 At a corrected age of 3 weeks he was reviewed in outpatients by a Consultant Neonatologist. His weight was said to be following between the 25th and 50th centile as it was on discharge and he appeared well cared for. The bloodshot eye was not mentioned by his parents.

7.26 A joint visit was planned with the Health Visitor and the CONI Coordinator but there was no access. The Health Visitor followed this up with a phone call to Mr H who reported Harry had lost 6 ounces in weight that week. This is a large weight loss in such a small child and is of concern due to the association with sudden infant death. However, the previous weight taken at the GP surgery appears to be an anomaly which may explain this.

7.27 The CONI Coordinator advised weekly weights (as per the CONI programme) and this was agreed with the Health Visitor.

7.28 The family continued to receive regular visits from the Health Visitor under the MECSH scheme[4].

7.29 During this time difficulties with feeding were reported with his parents reluctant to give feeds with the fortified milk recommended by the neonatal service with instead a preference for standard formula milk.

7.30 His weight gain also began to tail off - eventually crossing two growth centiles[5] over the last 6 weeks of his life.

7.31 On the day of his death (11 weeks corrected for his prematurity) he had been put to bed prone (on his front) in a bed (not his cot) and was subsequently found not to be breathing.

7.32 Resuscitation restored circulation but irretrievable brain damage had occurred though lack of oxygen and intensive therapy was withdrawn.

7.33 The initial working diagnosis was of a sudden infant death however the post – mortem revealed the presence of several fractures dated to three time periods indicating repeated episodes of trauma over the last 5 – 6 weeks of his life.

7.34 There was no history of accidental trauma which would explain this finding and non – accidental injury was deemed likely.

B Analysis of professional practice

[4] MECSH – Maternal Early Childhood Sustained Health Visiting - an intensive parenting programme designed to support families through pregnancy and up to 2 years. It is a tailored programme of intensive visiting designed to improve outcomes by working on a prevention and early intervention framework. It is voluntary.

[5] Centile charts show the normal range of an infant's/child's weight and tracks their growth. Crossing two centiles shows a failure of weight gain which is significant and may indicate the presence of an underlying medical condition or neglect.

8 Why did Harry die?

8.1 To understand what happened and why in this case, it is essential to deconstruct the key elements and analyse the themes identified to inform learning for future practice.

8.2 Harry died of the consequences of a cardiorespiratory arrest. The cause of his cardiorespiratory arrest was unascertained and therefore falls under the banner of a Sudden Unexpected Death in Infancy (SUDI) – see section 16 for discussion.

8.3 At the post-mortem examination he was found to have multiple fractures, the nature of which were most likely to be caused by non-accidental injury (physical abuse).

8.4 Physical abuse commonly coexists with neglect, of which there was some evidence, with Harry having inadequate weight gain in the latter weeks of his life. He was also living in a neglectful environment.

8.5 This environment also comprised recognised risk factors for Sudden Infant Death Syndrome (SIDS – cot death) including maternal smoking (antenatal and postnatal), lack of breast feeding and unsafe sleep practices. This was coupled with a history of previous unexplained infant deaths in the extended family.

8.6 The broader adverse circumstances of this child within this family include concerns of inadequate care of John in father's previous relationship, mental health issues of both parents, housing difficulties, poor family support, family history of previous social care involvement and inconsistent engagement with services.

8.7 Harry's prematurity was an independent risk factor for both child abuse and SUDI/SIDS.

8.8 Physical abuse was not the primary cause of death in this child but it is not possible to exclude neglect as a contributory factor to his unexplained cardiorespiratory arrest.

8.9 The commonality of risk factors for sudden unexpected death (including SIDS – cot death) and for child abuse is well recognised[6].

8.10 The key issues for this review to consider then are identification of physical abuse and neglect and the promotion of safe sleeping practices.

8.11 These however cannot be approached in isolation – the wider issue of minimising adverse family circumstances requires a coordinated multiagency and public health strategy.

8.12 Within these key issues are several themes identified initially by the review panel (please see Terms of Reference, Appendix 1) and further elucidated during the practitioners' event.

8.13 These are not novel and have been highlighted previously in both local and national Serious Case Reviews.

[6] Sidebotham P *et al* Triennial Review of SCRs

8.14 There are two specific features of this case which warrant particular analysis in order to emphasise their key role in the early identification of physical abuse and neglect – the significance of a "bloodshot" eye and faltering weight gain.

9 Significant episodes

9.1 There are two significant episodes which deserve further consideration of how practitioners responded to them.

9.2 Bloodshot eye – 2 months prior to death.

9.3 Harry was reported to have a bloodshot eye by the Family Support Worker. The eye is described as being red but not a diffuse pink as in conjunctivitis (infection of the eye). There was no eye discharge seen or reported. Ms H told the Family Support Worker that she had seen it two days previously. The Family Support Worker reported it to the Health Visitor.

9.4 Mr H had also phoned the Health Visitor after Harry's routine health surveillance to say that the red eye was resolving and that the GP had said this was as a result of straining at stool (although Harry's stools were described as "loose").

9.5 This did not prompt curiosity by the Health Visitor to either examine the eye more thoroughly or challenge father's (or the GP's) explanation given that straining at stool is not a recognised cause of a red eye in a healthy child.

9.6 The GP had not noticed any abnormalities of the eye at the 6 – 8 week check and denied having given this explanation to father. A phone call to the GP from the Health Visitor to discuss this would have raised concerns regarding the veracity of father's explanation and exposed this untruth. It is not clear how father came by this explanation.

9.7 As no clinician had seen the redness in his eye, there is some uncertainty as to whether this was inflammation or infection of the eye (sometimes termed "pink eye") or whether it was a subconjunctival haemorrhage[7].

9.8 Given the injuries that Harry was subsequently found to have sustained, the latter is a distinct possibility. Despite this uncertainty, it is crucial to ensure practitioners respond promptly to any reported finding which may indicate injury in a non-mobile infant.

9.9 Subconjunctival haemorrhages are known to be associated with non – accidental injury[8].

9.10 They are not associated with constipation in healthy infants (nor was Harry reported to have difficulty in passing stool).

9.11 Unless the eyes are held open with all quadrants of the sclera visualised, subconjunctival haemorrhages can be missed in young infants.

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[7] Bleeding into the sclera (white) of the eye.
[8] DeRidder C *et al* Subconjunctival Haemorrhage in Infants and Children *Pediatric Emergency Care* 2013; 29: 222 - 226

9.12 A previous Serious Case Review in Plymouth highlighted subconjunctival haemorrhage as a potential sentinel injury with the significance of this risk indicator being incorporated into multiagency training.

9.13 Sentinel injuries are those which herald future severe physical abuse. Recognition and action are therefore key to preventing serious injury[9].

9.14 Further curiosity may have led to a referral for a paediatric review should a subconjunctival haemorrhage have been confirmed and the implications recognised particularly in the context of this vulnerable family.

9.15 The timing of this possible haemorrhage predates the timescale of the limb fractures. It is possible that no further injuries would have been present or identified at this time had a medical assessment taken place.

9.16 It would however have served as a red flag and may have prompted multiagency involvement from this point with closer scrutiny of the family.

9.17 Faltering weight gain – 5 weeks prior to death.

9.18 In the five weeks prior to his death, regular monitoring had revealed Harry's weight gain was poor.

9.19 He was said to be taking reduced amounts of feed and was reported to have abnormal feeding behaviour (choking on feeds, moving arms around frantically during feeds).

9.20 There were also signs of increased stress on the family during this time including rent arears, threats of eviction due to the state of the house and Ms H having been in hospital with a serious health problem.

9.21 Over this time period his sibling had facial bruising, safe sleeping advice was not being followed (both parents continuing to smoke, apnoea monitor not being used, Harry sleeping downstairs whilst his parents were asleep upstairs) and his parents were reluctant to continue with weekly weight monitoring as required by the CONI programme and as indicated by his feeding problems and poor weight gain.

9.22 These changes in the family circumstances along with evidence of poor weight gain and failure to follow safe sleeping practice, should have prompted consideration of a review of the family's engagement with the programmes put in place to safeguard Harry.

9.23 As a minimum the case and the escalating life events/challenges should have been discussed through supervision although, given this change in the context of the known vulnerabilities of this family (mental health issues in both parents, deterioration in the state of the home), an immediate referral to re-engage Children's Social Care would also have been appropriate.

[9] Sheets LK *et al* Sentinel injuries in infants evaluated for child physical abuse *Pediatrics* 2013; 131: 701 - 707

10 Good practice

10.1 Practitioners' commitment to the care and support of children and families on their caseload was apparent and there were multiple examples of effective practice.

10.2 Practitioners recognised that this family were vulnerable and shared information appropriately and in a timely manner in the main.

10.3 There was good communication between midwifery services, Health Visitors and Social Worker including carrying out joint visits both before and after Harry was born.

10.4 Multiagency meetings were held to formulate plans for Harry's safe discharge from hospital and on–going care.

10.5 Given the family's vulnerabilities the health visiting service provided the MECSH[4] programme – an intensive parenting programme.

10.6 Prevention of sudden infant death syndrome and safe sleeping was discussed with parents by hospital and community health practitioners.

10.7 The risks to Harry from sudden infant death syndrome were recognised (smoking, prematurity, positive family history) and he was enrolled into the CONI programme.

10.8 Resuscitation training had also been given by the neonatal team prior to discharge.

10.9 There was good practice from the FSW sharing and following up information regarding the bloodshot eye. This is particularly notable for a non-clinician.

11 Identified themes for focus of future learning

11.1 The themes identified through case analysis and practitioner reflection did not reveal any novel learning areas but did replicate matters identified through previous local and national case reviews.

- Recognition of neglect
- Recognition and lack of curiosity around injuries concerning for physical abuse
- Lack of professional challenge
- Working with vulnerable families particularly with the challenges of disguised and/or inconsistent compliance
- Consideration of the wider family including siblings and prior relationships of parents

11.2 These will be considered in more detail below.

12 Recognition of neglect

12.1 All practitioners were aware of the home circumstances being unsuitable by virtue of the house and garden being cluttered with detritus and unclean. Action was taken to address this prior to discharge from the Neonatal Unit with the parents responding promptly at that point but this was not sustained.

12.2 This was a chronic issue but practitioners commented that the situation was no worse or even better than other families on their caseload. There is therefore a challenge in determining when low level concerns of "just about good enough" become "inadequate" and at risk of causing harm to children.

12.3 It is well recognised that practitioners can become desensitised to levels of neglect particularly when working in areas with high levels of deprivation and this can cause action paralysis. The chronicity and fluctuating nature of neglect can also cause difficulties in deciding at which point to act.

12.4 Practitioners also identified there was neglect of Susan's needs – it was highlighted that she was not always in appropriate clothes or shoes at school and was not supported by parents in her reading or homework. Again, this was not felt to be unusual for many families in this area.

12.5 Susan's attendance at school was poor but being addressed through the Education Welfare Service and was said to be improving at the time of closure of the Child in Need plan.

12.6 The danger of these being considered low level concerns and within the spectrum of normality for an area is that the cumulative effect of all these features of neglect is not recognised.

12.7 When parents and families are chaotic this can be mirrored in professional's thinking as they become overwhelmed by the complexity, nature and often the volume of work becoming "stuck" and unable to be proactive about protecting the child(ren)[10].

12.8 The impact on the child(ren) is then a qualitative issue which becomes challenging to address.

12.9 One tangible and therefore easily identifiable feature of neglect is failure to gain weight at the appropriate rate.

12.10 Harry was seen to have an inconsistent pattern of weight gain but the general trend was downwards across the centiles eventually crossing two weight centiles. This is well established to be a red flag for an organic cause or an indicator of neglect and should have prompted referral for a paediatric opinion. This advice is explicit on the Sheffield weight chart (used within the CONI programme).

12.11 In isolation this is unlikely to have led to investigations which would identify the fractures (which are since known to be present at this point), although may have resulted in further multiagency involvement and curiosity about the circumstances of the family and their level of engagement with services.

[10] Brandon M *et al* Understanding Serious Case Reviews and their impact DCSF Research Report June 2009

12.12 The immediate and long term negative impact of neglect on a child's health and welfare is well established[11]. Some of the barriers preventing practitioners from taking action include lack of knowledge of the impact of neglect, inadequate supervision arrangements and real or perceived constraints on resources[12].

12.13 The mind set of practitioners may also prevent them from acting on indicators of neglect including:

- Fear of being seen as judgemental
- Being distracted by the parent's needs and losing focus on the child
- Failure to understand the lived experience of all children in the family
- Misplaced understanding of the compliance of parents
- A reluctance to refer to Children's Social Care because of previous experience or perceptions of restrictive thresholds.

12.14 Effective supervision may mitigate these issues but putting the onus on the practitioner to take cases to supervision may be problematic. It depends on the practitioner recognising the risks and having the self–awareness necessary to see the need for supervision (see paragraph 12.7).

12.15 A robust supervision system will take into account the complexities and fluctuating vulnerabilities of families, encourage professional curiosity and enable practitioners to learn through reflective practice[13].

12.16 Plymouth Safeguarding Children Board published a multiagency "Neglect Strategy" in 2018 alongside a "Neglect Framework and Guidance". These can be easily found on the Plymouth Safeguarding Children Partnership website.

12.17 These documents were published after Harry died however it is disturbing that when this was discussed at the practitioners' meeting, not all agencies were aware of them.

12.18 Local multiagency policies and strategies such as these can do much to support and educate practitioners and underpin effective multiagency practice.

12.19 Dissemination of such policies can be straight forward with current electronic methods however ensuring that all practitioners are aware and have assimilated the content is a continued challenge for many organisations.

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[11] Research in Practice/NSPCC/Action for Children Child Neglect and its relationship to other forms of harm – responding effectively to children's needs

[12] Brandon M *et al* Missed opportunities: Indicators of Neglect – what is ignored, why and what can be done 2014 Department for Education

[13] Brandon M *et al* Complexity and Challenge: a triennial analysis of SCRs 2014 – 2017 March 2020 www.gov.uk

13 Recognition of injuries concerning for physical abuse

13.1 Bloodshot eye

This has been discussed in section 9.

13.2 Fractures

13.3 Harry had multiple metaphyseal fractures of his lower limbs. These are highly specific for non–accidental injury particularly when multiple and of different ages[14].

13.4 Infants can have multiple fractures without any of the usual external signs of injury.

13.5 These fractures will have been painful when they were inflicted and would remain so particularly on handling (e.g. for dressing, nappy change etc) until healing commenced.

13.6 Whilst he received several visits over the timescale of his fractures and was observed naked during weighing, the lack of external signs would make identification or even suspicion of injury challenging.

13.7 Any distress seen on routine care activities due to pain from the fractures would be difficult to distinguish from the almost universal dislike of small infants of being undressed.

13.8 It was commented that he was generally a quiet baby who did not cry. This is also a concern as quiet, passive babies can be a sign of emotional neglect[12].

13.9 Practically, fractures of this nature usually remain hidden unless other features of potential abuse prompt further investigation. This does imply that practitioners must be alert to indicators of concern (bruising in sibling, other signs of neglect) particularly in the context of a vulnerable family. The co – existence of neglect with physical abuse is common and should be borne in mind by all practitioners.

13.10 Bruising to sibling

13.11 Susan was noted to have facial bruising. She was said to have walked into a door. This may have been an innocent (accidental) explanation but in the context of the challenges this family were facing at the time further curiosity would be justified.

13.12 Lack of recognition of neglect and injuries suspicious for abuse in the context of a family with known vulnerabilities raises concerns that the level of knowledge of the indicators of neglect are not well embedded in all partner agencies and that learning from previous serious case reviews has not been assimilated into practice.

[14] Royal College of Paediatrics and Child Health Systematic Review : Fractures 2018 www.pco.org

14 Professional challenge

14.1 Some practitioners raised concerns that the Child in Need plan had been discontinued too soon. There is no evidence that this decision was robustly challenged by partners at the time.

14.2 Discussion during the practitioners' meeting indicated that the Child in Need meeting was positive and whilst all agencies were aware of the continuing vulnerabilities of this family, it was felt that there was sufficient support in place from health and school/Education Welfare Service that there was no additional role for Children's Social Care at that time.

14.3 Given the level of intensive visiting through the MECSH and CONI programmes, this seems reasonable decision at that point.

14.4 Lack of professional challenge is commonly noted in the analyses of Serious Case Reviews and all practitioners should continue to be mindful of this potential pitfall.

15 Management of vulnerabilities

15.1 The family were identified as vulnerable and appropriate referrals were made during early pregnancy. The approach during the post–natal period was similarly proactive.

15.2 The parents were recognised to be particularly childlike and both had mental health issues. They appeared to be very co-dependent.

15.3 At times they were cooperative (see paragraph 7.9) but other behaviours indicated a lack of compliance (not using fortified milk and resisting frequent weighing, not using apnoea monitor or complying with safe sleeping guidance) or disguised compliance (father being untruthful about comments from GP regarding the bloodshot eye).

15.4 These are discussed above in sections 11 and 12.

15.5 Resource issues to support perinatal mental health concerns.

15.6 The antenatal assessment completed by Children's Social Care suggested midwifery make a referral to the perinatal mental health team. This did not occur as the perinatal mental health service will only take on women with severe mental illness e.g. psychosis.

15.7 This is a recently commissioned service but appears to only address the small number of women with a psychotic illness.

15.8 The much larger number of women who have mental illness which does not fall into the category of psychosis are directed to the "Options" service. This is an on – line provision for which there is a waiting list. The onus is on the patient to self–refer. It also relies on women who may be struggling with anxiety and depression to have access to a computer and to be motivated to work through the on–line sessions.

15.9 Given the number of times mental health concerns including post–natal depression (including in fathers) are mentioned in Serious Case Reviews, this may be an area which warrants further consideration of the structure and availability of resources considering the known risks, not just to parents, but also to their children.

15.10 Role of domestic abuse

15.11 There were three safeguarding enquiries through the Police which involved domestic abuse between Ms H and Mr H or Ms H in the presence of Child J.

15.12 Standard processes were followed. All took place prior to Ms H's pregnancy with Harry.

15.13 On these three occasions the level of concern generated a ViST which were each rated green[15]. These are not routinely shared with other agencies.

15.14 Consideration should be given to the potential safeguarding risks underlying multiple ViST reports. Lack of information sharing consequent on ViST reviews being graded as low risk has been identified recently as a concern through a formal multiagency review and therefore will not be considered further here to avoid duplication.

15.15 Whilst it is known that domestic abuse appears frequently in Serious Case Reviews and that the family were at risk, this does not appear to be a major contributor in this case. Hidden abuse cannot be excluded.

15.16 **Recognition of non-compliance/inconsistent engagement**

15.17 Review of Harry's management identifies inconsistent engagement of the family with services particularly in following advice regarding safe sleeping and his nutrition. There is some evidence that if families understand the purpose and potential consequences of interventions, they are more likely to comply.

15.18 Inherent in this approach of working **with** families (rather than a paternalistic approach) is a greater demand on practitioners' time which may be a scarce resource.

15.19 There were multiple aspects of Harry's management that his parents were reluctant to fully engage or comply with including:

- Not wanting to stay in hospital for two nights before discharge from the Neonatal Unit
- Resisting weekly weights
- Not wanting the Family Support Worker to visit
- Not following safe sleeping advice
- Not giving the recommended milk
- Not using the apnoea monitor.

[15] Key elements of the Devon and Cornwall Police's Single Safeguarding Policy (SSP) are the **ViST (Vulnerability Screening Tool**), a risk assessment tool employed by Police Officers and Staff to assess vulnerability and the Central Safeguarding Team (CST), which receives and processes the ViST to identify cases requiring further multi-agency assessment and intervention. ViST ratings are RAG rated (red, amber and green) green is the lowest risk level.

15.20 It should be understood that Harry's parents were not unusual in suspending use of the apnoea monitor. Many parents, particularly when their infants are graduates of a neonatal unit find the false alarms very stressful. This does mean then that compliance with safe sleeping practice is crucial.

15.21 In difficult to engage families who resist multiple interventions or advice, it is important to "stop and think", essentially stepping back and taking an overview particularly in the context of the known vulnerabilities of the family. Supervision can be an effective support in this situation providing a challenge to overly optimistic decision making and regaining perspective when practitioners are overwhelmed with the complexities of families.

15.22 There was only single agency involvement during the latter weeks of Harry's life. Engaging partner agencies to formulate a multiagency approach with a strategy and planned interventions for lack of engagement could have provided a more comprehensive support around this family.

15.23 It is necessary to consider the timescale over which Harry's fractures and poor weight gain occurred (5 weeks prior to death) giving limited opportunity for intervention. The corollary is then that indicators of concern should be acted on promptly. This may require seeking support through *ad hoc* supervision, which must be readily available or engaging in "in principle" discussions with partner agencies for advice.

16 Sudden death in infancy

16.1 Sudden unexpected death in infancy (SUDI) is a descriptive term and refers to deaths which would not have been reasonably expected in the previous 24 hours and for which no pre–existing medical cause of death is apparent[16].

16.2 A proportion of SUDI are classified as Sudden Infant Death Syndrome (SIDS) which is defined as: "*the sudden and unexpected death of an infant under 12 months of age, with onset of the lethal episode apparently occurring during normal sleep, which remains unexplained after a thorough investigation including performance of a complete post - mortem examination and review of the circumstances of death and the clinical history*."[16]

16.3 The risk factors for SIDS are well known and include prematurity, male sex, antenatal and postnatal exposure to cigarette smoke and poor sleep practices including prone positioning, over dressing and use of soft bedding including duvets.

16.4 Harry had been placed face down on a duvet in a bed.

16.5 Prevention of SIDS includes avoidance of exposure to cigarette smoke and the promotion of safe sleeping practices. These were discussed both antenatally and postnatally with his parents.

16.6 The risk factors for SIDS overlap with many of those vulnerabilities seen in child abuse cases.

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[16] Royal College Pathologists/Royal College of Paediatrics and Child Health Sudden unexpected death in infancy and childhood Multiagency guidelines for care and investigation November 2016 www.rcp.ac.uk

16.7 However it must be emphasised that the presence of multiple risk factors for SIDS does not equal causation.

16.8 It is not possible to determine whether abuse (neglect) was the prime cause or was a significant contributor to his death. It is indisputable that, due to the presence of multiple metaphyseal fractures, he had suffered at least three episodes of physical abuse.

16.9 A recent review of Serious Case Reviews has identified a significant proportion of cases where the deaths are felt to be related to abuse but maltreatment is not identified as the primary cause.

16.10 This includes cases of sudden unexpected death where there were concerns regarding the adequacy of parental care but that the cause of death was either unascertained or due to natural causes[12].

16.11 Harry's risk of sudden unexpected death in infancy was recognised and evidence based measures were put in place to minimise the risk (CONI programme).

16.12 However there was no evidence of reassessment or proactive management of this risk once reduced engagement with this programme and poor sleep practices were identified.

16.13 It was reported that there is a difference in the failure to thrive policy in the Health Visiting service and that used in the CONI programme. This should be reviewed and aligned to ensure all practitioners are using the same guidance to avoid confusion.

16.14 This case provides support for the effectiveness of the Child Death Review process which aims to identify child homicides which may otherwise have been missed or to identify where child abuse may have contributed to the circumstances of death without necessarily being a direct cause.

16.15 The recent publication of the Child Safeguarding Practice Review Panel's report into Sudden Unexpected Death in Infancy[17] is timely.

16.16 The publication documents a comprehensive review of cases of sudden death and in particular focuses on a strategies for prevention. This includes a proposal for practical intervention using a multiagency practice model – "Prevent and Protect".

16.17 The review highlights that research evidence supports using interventions which are "*personalised, culturally sensitive, enabling, empowering, relationship building, interactive, accepting of parental perspective, non-judgmental and are delivered over time*".

16.18 It is important that these interventions start antenatally and continue with the message through pregnancy and infancy. Such a programme also needs to be responsive and flexible to the changing circumstances of parents and families.

16.19 What is notable about this case is that the vulnerability of the family for safeguarding the welfare of Harry including reducing his risk of sudden death in infancy was recognised and measures were put in place to mitigate this.

[17] Child Safeguarding Practice Review Panel: SUDI in Families at Risk 2020

16.20 These were not once only interventions but this advice was not followed. The recent national review may contribute to a local exploration of how practice can be adapted to promote active change in parental behaviours.

17 Summary

17.1 Harry was 11 weeks old (corrected age) when he was found in bed not breathing and unresponsive. He was resuscitated with achievement of return of circulation but irretrievable brain damage had occurred and further medical intervention was deemed futile.

17.2 A post-mortem revealed multiple fractures occurring on at least three occasions over a 5 – 6 week period before his death. During this time there had also been inadequate weight gain.

17.3 The family had several vulnerability factors including risk factors for Sudden Infant Death Syndrome (cot death).

17.4 Whilst the existence of physical abuse was irrefutable this did not cause his death but neglect, including non-compliance with safe sleeping practices, may have contributed.

17.5 Review of professional involvement revealed initially a multiagency approach to managing this family which was stepped down to a broadly health led plan.

17.6 Changes in the circumstances of the family with maternal ill health, deterioration in home conditions and inconsistent compliance with safe sleeping and nutritional advice, fit within the timescale of the episodes of fractured limbs.

17.7 Identifying this toxic combination of circumstances will always be challenging but clues may be provided in the form of sentinel injuries or changing patterns of behaviour and curiosity should be maintained at all times.

17.8 Any change in family contexts or presence of concerning features in a vulnerable child should prompt a critical analysis of whether interventions may need to be modified including whether stepping up engagement of partner agencies is required.

17.9 Support for practitioners working with complex cases particularly in areas with high levels of deprivation is crucial; a robust framework of supervision is essential.

17.10 The challenge will always be taking the leap forward from identification of risk to making a lasting change in behaviour. This requires a sustained and collaborative approach from agencies to engage families in understanding the potential impact of their circumstances and how they can modify this to improve the outcome for their children (and themselves). Use of evidence based interventions is crucial.

18 Considerations for Plymouth Safeguarding Children Partnership (PSCP)

18.1 The PSCP may wish to explore whether individual agencies have made their practitioners aware of sentinel injuries and in particular subconjunctival haemorrhage as a harbinger of ongoing occult or subsequent severe non–accidental injury.

18.2 Given the number of times mental health concerns including post–natal depression (including in fathers) are mentioned in Serious Case Reviews, the Partnership may wish to consider whether provision for low or moderate levels of mental ill health is adequate given the known risks not just to parents but also to their children.

18.3 The Partnership may find it helpful to review the evidence base and suggested interventions in the recently published national thematic review into Sudden Unexpected Death in Infancy and evaluate their current multiagency approach to prevention of Sudden Unexpected Death in Infancy in vulnerable families against this benchmark.

18.4 The Partnership may wish to review their processes for introduction, dissemination and implementation of multiagency strategies to ensure all front line practitioners are aware of these resources.

18.5 Given the crucial role that supervision plays in supporting practitioners in complex cases particularly where there are issues of disguised or inconsistent compliance, agencies should ensure their supervision frameworks are robust. Commissioners of these services should satisfy themselves that supervision as a crucial aspect of safeguarding practice is well–embedded in services and carried out to a high standard.

Appendix 1

Terms of reference

LOCAL CHILD SAFEGUARDING PRACTICE REVIEW
TERMS OF REFERENCE

CHILD REFERENCE	**SCR 026**
DATE:	**19 February 2020**

1	**INTRODUCTION**
1.1	The aim of this review is to identify improvements that can be made to better safeguard children and to prevent or reduce the risk of similar incidents.
1.2	The review will undertake a rigorous and objective analysis of what happened and why. It will consider whether there are systematic issues, and whether and how policy and practice need to change.
1.3	It should be noted that the review is not being conducted to hold individuals, organisations or agencies to account as there are separate processes for this.
1.4	This review was commissioned by the Plymouth Safeguarding Children Board. Under the Children Act 2004, as amended by the Children and Social Work Act 2017, Local Safeguarding Children Boards were replaced with new arrangements put in place by the three safeguarding partners (local authorities, chief officers of police and clinical commissioning groups) to work together with relevant agencies to safeguard and protect the welfare of children in the area. These arrangements came into effect on 29 September 2019 and can be seen at https://www.ptscp.co.uk/
1.5	Some LSCB SCRs were not completed and/or published at the point the new safeguarding arrangements began to operate. Where this is the case transitional arrangements allow LSCBs to continue for a 'grace period' of a maximum of 12 months from that point to complete and publish these SCRs. The latest date for completion and publication of an LSCB SCR is 29 September 2020.
2	**CASE SUMMARY**
2.1	**Summary of Serious Incident:** Child 026 was a 4 month old baby boy who was rushed into Derriford ED on 16 May 2018 having been found by Mum in cardiac arrest at home address. Child 026 was taken to Bristol Hospital, but sadly died on 19 May 2018. A report from the radiologist states that the skeletal survey revealed a fracture to the right proximal distal tibia and an irregularity of the right femur that may also be a fracture and the Plymouth Coroner requires a forensic PM. There are also differing accounts as to where Child 026 had been sleeping. **Information about the Family:**
2.2	Child 026 lived at the home address with both his Mum and Dad and his half-sister. Mum, Dad and half-sister are each linked to number of safeguarding enquiries, and concerns relating to domestic abuse.
3	**REVIEW TEAM**

3.1	**Name of Lead Reviewer:** Dr Deborah Stalker
3.2	**Membership of the Review Team** • DCI Rachael Bentley, Head of Public Protection Unit, Devon & Cornwall Police (Senior Investigating Officer & liaison with Crown Prosecution Service) • Juanita Scallan, Service Manager, Children Young People & Families, Plymouth City Council • Sarah Shelley, Designated Nurse Safeguarding Children, NHS Devon CCG • Hannah Hamlin, Principal Educational Psychologist, Plymouth City Council • Caroline Wilson, Lead Development & Training Officer, Plymouth Safeguarding Children Partnership • Dr Carolyn Adcock, Paediatric Consultant, University Hospitals Plymouth NHS Trust • Tracey Watkinson, Business Manager, Plymouth Safeguarding Children Partnership.
4	**SCOPE OF THE REVIEW**
4.1	**Time period to be considered by the Review and rationale:** The time period shall be from date of knowledge of pregnancy until date of death of Child 026, i.e. 10 July 2017 until 19 May 2018. This time period reflects the potential learning likely to be achieved and support understanding pattern of any child neglect and whether early help interventions were or could have been beneficial.
4.2	**Key issues to be addressed by the Review:** • Previous history of father/recognition of family context • Working with vulnerable parents • Recognition of neglect and action taken • Recognition of disguised/inconsistent compliance • Professional optimism • Recognition of injuries concerning for physical abuse • Lack of professional curiosity • Information sharing and triangulation • Lack of professional challenge • Supervision • Record keeping.
4.3	Whilst it is acknowledged that the undertaking of the review itself may identify additional areas for consideration and further learning, the primary themes listed above should be maintained as the parameters for the review, unless additional factors come to light. In such an event the Independent Lead Reviewer shall report back to the Review Panel to establish and agree next steps.
5	**PLANS TO INVOLVE CHILDREN AND FAMILY MEMBERS**
5.1	Working Together to Safeguard Children 2018 highlights the crucial importance of inviting families to contribute to reviews. This will help ensure that the review reflects the child's perspective and the family context.
5.2	The mother and father of Child 026 will be sensitively invited to contribute to the review. The mother and father will be notified of the SCR and contacted by the Independent Chair of the

	Review Panel or their nominee to facilitate their contribution. The timing of this invitation and dialogue will be agreed with both the Police and if relevant the Crown Prosecution Service, to ensure that evidence for criminal proceedings is not compromised.
6	**METHODOLOGY**
6.1	A systems based approach will be utilised. This is consistent with both the guidance in Working Together to Safeguard Children 2018 and the principles of systems methodology recommended by the Munro Report[18].
7.	**LEGAL CONSIDERATIONS**
7.1	The case is subject to criminal investigation/proceedings. The Review may not necessarily be formally or fully completed until the conclusion of criminal proceedings. The PSCB will ensure any necessary delay in concluding the Review has no impact on using the identified learning to improve practice and outcomes for children, young people and families.
7.2	The Review will be 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".
8.	**OTHER CONSIDERATIONS**
8.1	There are no racial, cultural, linguistic, religious or other key issues/factors relating to the background of the child or members of their family.
9.	**MEDIA ENQUIRIES**
9.1	Media interest should be directed to the PSCB Business Manager, who will liaise formally with the Chair of the PSCB, regarding an appropriate media response in accordance with the PSCB media strategy.
9.2	All press releases will be agreed by the PSCB Business Support Manager following consultation with the communication teams for the agencies contributing to the Review for Child 026.
10.	**TIMELINE AND KEY DATES**
10.1	Information Returns submitted: 24 February 2020
10.2	Reflective Practitioner Meeting: 3 March 2020
10.3	First Draft Review due: 23 March 2020
10.4	Review Panel Meeting: 23 March 2020
10.5	Practitioner Review of learning identified: TBC

[18] The systems approach described in this guidance was developed base on the model described in SCIE Guide 24: *'Learning together to safeguard children: developing a multi-agency systems approach for case reviews'* by Dr Sheila Fish, Dr Eileen Munro and Sue Bairstow (January 2009) and following research into best practice around Serious Case Reviews.

10.6	Second Draft Review due:	TBC
10.7	Final Draft Review due:	TBC
10.8	Final Draft Review presented to PSCP:	TBC
10.9	Publication of Review:	September 2020