MSCB

MANCHESTER SAFEGUARDING CHILDREN BOARD

Manchester Safeguarding Children Board

SCR Learning Report: Child L1

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Learning Report

This report summarises the key learning points from a Serious Case Review (SCR) in respect of Child L1, and has been written as a learning tool for agencies and practitioners. An SCR is not an investigation intended to attribute blame, but rather to identify what went wrong and how similar failures can be avoided by learning from this case. It is also an opportunity to identify good practice.

Who is Child L1?

Child L1 was born in August 2016 and lived with their mother, father and sibling who was eleven months older. Mother had come to the UK from Pakistan and was quite isolated. Father was of Iranian descent and had lived in the UK for many years. Child L1 was born prematurely and nursed in a neonatal intensive care unit (NICU) for the first three weeks of their life. After concerns arose over a mark on Child L1's abdomen, L1 and their elder sibling were considered to be children in need (CiN). In order to determine the needs of Child L1 and their elder sibling, children's social care were planning to carry out a child and family assessment (CAFA) when Child L1 sustained significant head injuries consistent with being severely shaken.

Why was the SCR carried out?

It was decided to conduct a SCR because Child L1 had been seriously harmed and abuse was suspected. The MSCB was also concerned that the risk of serious harm to Child L1 and their elder sibling was not acted upon appropriately. The SCR covered quite a short period, beginning on 13th July 2016 when mother, who was pregnant with Child L1 at that point made disclosures of physical abuse of Child L1's elder sibling and domestic abuse of herself (mother) by father. The review period ended on 30th September 2016 when Child L1 was admitted to hospital with serious head injuries.

What did the SCR find?

When mother and Child L1's elder sibling – then aged ten months - attended their GP practice for a routine appointment with the practice nurse on 13th July 2016, mother disclosed that father regularly became angry when Child L1's elder sibling cried and responded by physically assaulting mother and the child. Mother showed bruising to her arm which she said had been caused by father. Mother was extremely anxious about the impending birth of her second child as she feared father would harm the new born baby when it cried. Mother appeared isolated and in fear of father.

Once the practice nurse began to steer the conversation towards referring mother and her child for support, mother appeared to have second thoughts and by the end of the conversation was "begging" the practice nurse not to take any further action. Mother left before the practice nurse could carry out anything more than a cursory examination of the unclothed parts of Child L1's elder sibling's body.

The GP practice nurse submitted a safeguarding children referral which was shared with children's services emergency duty team (EDT) and a request for a strategy meeting was sent to the police. Prior to submitting the safeguarding children referral, the GP practice nurse contacted children's social care's contact centre by telephone and the details of the case were recorded by a contact centre officer. The summary of the case recorded by the contact centre officer omitted the fact that mother was seven months pregnant with Child L1. Unfortunately, this incomplete summary was the version of events which was shared with the police who declined the strategy meeting request.

Children's social care decided to carry out a child and family assessment (CAFA) and worked with the health visitor to engage with mother and used the nine month assessment of Child L1's elder sibling to examine the child unclothed and establish that there were no apparent marks on their body. Mother continued to distance herself from the disclosures she had earlier made to the GP practice nurse. The plan was to support mother in order to try and reduce her isolation.

Prior to the completion of the CAFA, Child L1 was born prematurely in Norwich whilst the family were visiting father's relative. Neonatal staff in Norwich and Wythenshawe, where Child L1 was subsequently transferred to, were not aware of the prior safeguarding concerns relating to this family. Wythenshawe NICU was subsequently alerted to these concerns by the health visitor. Concern was expressed about the infrequency of hospital visits to Child L1's by their parents.

Following Child L1's discharge from hospital the CAFA was completed by children's social care which informed their decision to close the case. Almost three weeks after Child L1's discharge from hospital, the health visitor noticed a mark on Child L1's abdomen which was referred to the GP who arranged for a child protection medical to be carried out at Wythenshawe hospital the same day. The paediatric consultant felt that the mark was unlikely to be a bruise but arranged for Child L1 to be admitted so that the mark could be monitored. Child L1 was seen by several paediatric consultants over the next few days during which the mark faded from view. Ultimately it was concluded that the mark was not a bruise and was possibly of vascular origin. A strategy meeting was held at which it was decided that a further CAFA would be completed and that Child L1 and their elder sibling would be monitored as CiN. Ten days later Child L1 was admitted to hospital after being found unresponsive whilst in the care of their parents. The medical opinion was that L1's injuries had been caused by violent shaking.

Identified Learning Points

There was much good practice including the GP practice nurse doing well to elicit a significant amount of information from mother about the risks she, her child and unborn child faced from father. Both health visitors also worked affectively to take necessary action and prompt other agencies to take action. Maternity services developed a safeguarding plan for mother and her unborn Child L1.

The summary of mother's 13th July 2016 disclosures recorded by the contact centre officer from telephone contact with the GP practice nurse became the definitive account of the case which was shared with EDT, children's social care and the police. Unfortunately, that summary omitted reference to mother's pregnancy. (Additionally, the domestic abuse section of the record completed in the contact centre was left blank.)

However, the grounds on which the request for a strategy meeting was declined by the police do not stand up to scrutiny and the threshold the police suggested for re-referral back to them made any re-referral unlikely. Although several agencies were unhappy with the decision not to hold a strategy meeting, the police decision went unchallenged.

Domestic abuse policies lack clarity on the steps for practitioners to consider when victims, such as mother, make domestic abuse disclosures and then decide that they do not wish to pursue or decide they wish to retract their allegations. Where the risk of domestic abuse is considered to be high, a MARAC referral can be considered irrespective of whether the victim consents. Where a case falls below the high risk threshold, there appears to be an absence of guidance for practitioners.

Following mother's 13th July 2016 disclosures, the GP practice planned to reach out to her, check on her welfare and that of her children and possibly encourage her to repeat her disclosures. This approach was unsuccessful partly because the practice is a busy walk-in centre and relied heavily on part time staff which made internal communication more difficult.

Child L1's out of area birth represented a challenge to systems for sharing safeguarding information. By the time Child L1 was repatriated to Wythenshawe hospital's NICU, mother was no longer a patient so her patient records - which contained the safeguarding plan for Child L1 prepared by maternity services - were not referred to. Nor was a check made of the hospital's shared drive on which staff would also have found a copy of the safeguarding plan under mother's name.

The outcome of the examination of the mark on Child L1's abdomen by paediatric consultants appeared to become the sole focus of professional concern whilst the wider risk picture, of which the suspicious mark was just one important element, received much less attention. The paediatric consultants received only limited information from children's social care about previous and current safeguarding concerns about Child L1 and L1`s elder sibling

The CAFA which was the basis for children's social care decision to close the case was insufficiently comprehensive with continuing and fresh concerns not fully taken into account.

An effective safeguarding system need practitioners who are prepared to challenge decisions in a constructive manner together with processes for resolving professional disagreements. This did not happen when the police declined the strategy meeting.

Abusive head trauma (commonly known as shaken baby syndrome) is the leading cause of death and long term disability for babies who are harmed. Research suggests a relationship between the normal period of peak crying in babies and the incidence of babies subject to abusive head trauma. Excessive crying in babies can be difficult to manage for parents who need to be advised on how to manage episodes of prolonged crying.

Recommendations to the MSCB:

- The Board requests children's social care to review the practice by which they record and disseminate information from safeguarding children referrals in order to ensure that what is recorded and shared with partner agencies is as accurate and comprehensive as possible.
- The Board obtains assurance that partner agencies fulfil their statutory obligations to ensure strategy meetings take place when necessary and are inclusive of all necessary partner agencies.
- The Board shares this SCR overview report with Manchester Community Safety Partnership and requests that partnership considers developing practitioner guidance on options available to them when a victim decides not to pursue, or retracts allegations of domestic abuse. This will also be integrated into the IRIS training programme.
- The Board requests children's social care to reinforce the importance of completion of the domestic abuse section of the contact screening (child) form where a safeguarding children referral includes concerns of domestic abuse.
- The Board obtains assurance that systems by which maternity services in Manchester access safeguarding information in respect of out of area births are robust and adhered to by staff.

- The Board shares a copy of this SCR overview report with Norfolk LSCB so that the latter board is aware of the role played by Norwich University Hospital in this case.
- The Board enquires how widespread is the problem of paediatric consultants being provided with insufficient information about safeguarding concerns ahead of child protection medicals in order to consider what action to take.
- The Board requests children's social care to make use of the learning from this case to challenge the quality assurance process for CAFA completion.
- The Board seeks to influence the developing Greater Manchester abusive head trauma strategy in order to ensure the strategy to prevent abusive head trauma in babies is as effective as possible.

Additional Resources

The final SCR report in respect of Child L1 is available from the MSB website
https://www.manchestersafeguardingboards.co.uk/resource/serious-case-reviews/