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Leicester Safeguarding Children Board

SERIOUS CASE REVIEW

Subject: Baby Z
Born 06.02.2012

OVERVIEW REPORT

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1. INTRODUCTION

a. Introduction to the circumstances leading to the Serious Case Review

On 12.10.12 Baby Z was taken to the local hospital's Emergency Department by her parents who reported that "she had not been herself" and had not been feeding.

Initial examination of the baby revealed bruising and swelling to the right lower leg and bruising to the left side of the chin. An X-ray revealed multiple fractures to the leg. A CT scan identified swelling and fractures to the skull.

Further investigations confirmed the following injuries:

- multiple bruising
- 4 x fractures to the ribs, one is callusing indicating older injury
- suspected tibia fracture
- 2 x fracture to skull (1 x both sides)
- bleeds to the brain
- swelling to left side of brain, both front and rear area
- extensive bleeds behind both eyes
- "bucket handle" fracture to Femur (upper leg) fracture – likely to be caused by shaking
- healing reaction to lower leg. Mild angulation of fibular. Further fractures to both legs, 5 fractures in total.
- "bucket handle" fracture to distal humeral (Arm) and borderline fracture to lower arm (on side of thumb).

The conclusion from medical experts was that some of the fractures were caused up to 3 weeks before the head injuries, i.e. "multiple episodes of non-accidental injury".

Parental explanations included the suggestion that the baby bruises easily and that mother had massaged the baby daily with oil and at times the massaging was "vigorous". The injuries were not consistent with parental explanations.

The Police commenced a criminal investigation and both parents were arrested, charged and detained in custody. On 19.8.13 the Crown Prosecution Service withdrew their evidence against the father; and the mother pleaded guilty to Section 20 Grievous Bodily Harm. At a later hearing on 13.9.13 she received a 2½ year custodial sentence. On 24.12.13 Mother was removed from prison and sent back to India as part of the UK Visa & Immigration Service's "Facilitated Return" Scheme".

b. Introduction to the family

The nuclear family scoped into this Serious Case Review comprises

Father – Aged 23 at the time of the incident

Mother – Aged 31 at the time of the incident

Subject Child – 6.2.12

There are no references in contemporary agency records up to October 2012 to the extended family members (who have subsequently been identified).

c. Introduction to the child

Following her presentation to hospital on 12.10.12, the baby was ventilated for 2 days until she could breathe independently. A Section 47 investigation commenced immediately with Children's Social Care initiating Care Proceedings; and she has remained in the same foster home up to the present time.

An early neurological report states that: "There would be a wide range of neurological disabilities as there are a variety of injuries identified on MRI. She will need long term cognitive support in the community and rehabilitation.

The most recent description of Baby Z's development is as follows:

> . . . has been assessed to be 'severely visually impaired' as a result of the brain damage. She has been fitted with a gastrostomy tube so she is now fed directly into her stomach rather than through the nasal gastric tube. She continues to refuse all food and liquids by mouth. She has been having 'absences' – up to 3-4 times a day, and is being tested for epilepsy. She can now sit unaided for up to 10 mins but cannot walk, crawl or stand. She now has a specialist wheelchair and a standing frame to try and teach her brain about weight bearing. She has limited use of her left arm and no use of her left hand.

In later sections of this report and prior to her injuries, at various times there were descriptions such as:

- "mother and baby were bonding"
- "gaining weight and thriving"
- "attaining developmental milestones"
- "active and alert"
- "vocalising and smiling"
- "mobile by rolling"
- "looked well"

d. Introduction to parents and their immigration status

Parents originate from the Punjab. In March 2011 mother applied for a Tier 4 Student Visa. This was granted and she was issued with a Student Visa on 5.4.11, valid until 18.8.12. As a consequence, father was issued with a visa (the same dates apply) as a dependent of a Tier 4 student.

Mother's visa permitted her to study a post-graduate diploma (NVQ Level 7) at the International College in Leicester between April 2011 and April 2012. Both parents were permitted to take part-time work up to a maximum of 10 hours per week.

In February 2012 the Sponsor Licence of the International College was revoked. Therefore consideration was given by the UK Border Agency as to whether mother's Student Visa should be curtailed. The decision taken by the UK Border Agency on 7.3.12 was not to curtail mother's leave due to:

- mother was not responsible for the non-compliance of the sponsor
- there was less than 6 months leave remaining.

(The UK Visas and Immigration have reported that this is standard procedure, i.e. allowing the applicant to remain in the UK until the end of their visa in order to enable them to switch to another college to complete their studies.)

As mother has been convicted and her sentence is over 12 months, she will be dealt with as a Foreign National Offender (FNO) and automatic deportation provisions will apply. The father is classified as a "Visa Overstayer"[1] and under other circumstances he would be "administratively removed". However, due to the fact that he is a party in the Care Proceedings in relation to Baby Z, he has been granted "Immigration Bail"[2].

e. Introduction to the social and community context; and to the LSCB

Leicester is a large city in the East Midlands with a population of approximately 306,600 and the City Council believes that there may be a population undercount of around 30,000 people, 10% of the city's population. There are approximately 78,200 children and young people aged 0 – 19, representing 25% of the total population.

Of 326 local authority areas in England, Leicester is ranked as the 25th most deprived local authority according to the National Index of Deprivation (2010). Deprivation is wide-cast, 41% of Leicester's population live in the 20% and a further 34% live in the 20-40% more deprived areas in England.

[1] A Visa Overstayer means that he has no lawful basis to remain in the UK.
[2] Having been released from custody, he has to report to the Midlands Enforcement Unit in Solihull weekly.

Leicester City is ethnically diverse compared to England as a whole, 36% of Leicester's residents are from Black, Minority, Ethnic backgrounds compared with only 13% in England overall and approximately a quarter of Leicester's population are of South Asian origin (Leicester City Council 2012, Leicester City Children's Trust 2011).

2. THE PROCESS

2.1. Introduction to the process

At a meeting of the Leicester Safeguarding Children Board Serious Case Review Subcommittee on 6.11.12, the recommendation was made to the Chair of the Board that a Serious Case Review should be invoked. The Chair subsequently approved this decision (on 29.11.12) and the case was registered with the Department of Education and Ofsted.

An Independent Chair of the Serious Case Review Panel was appointed, and an Independent Overview Report Author. Membership of the Panel and brief profiles of the Chair and Author appear at Appendix (i).

In the spirit of systems methodology, Terms of Reference are not produced but questions for consideration were drafted; these appear at Appendix (ii).

An integrated chronology was prepared as a working tool for the Panel in general and for the Overview Author in particular.

Agency Individual Management Reports were duly commissioned; and authors and their senior officers with sign-off responsibilities were identified.

The first Serious Case Review Panel meeting was held on 10.1.13 and four subsequent meetings have been held. Significant delays have ensued due to:

a. performance and disciplinary proceedings
b. the status and methodology of this Serious Case Review, ie. whether it have been conducted as a systems learning process (eg. Social Care Institute for excellence or a Serious Incident Learning Process)

2.2. Engagement with the family

Both parents were informed that a Serious Case Review was being undertaken; and plans were made to offer them the opportunity of an interview in which they could share their experiences of the agencies involved and the services offered. Separate letters were sent to each parent but the LSCB Office has received no reply from either parent.

3. SUMMARY OF AGENCY INVOLVEMENT AND INDIVIDUAL MANAGEMENT REPORTS

3.1. Leicester City Housing

No records – the family lived in a private tenancy.

3.2. Leicester City Children's Social Care

No involvement and the family not known prior to the October 2012 injuries (but, of course, Children's Social Care are now very heavily involved as a corporate parent as the child is now looked after).

3.3. UK Visas & Immigration

No direct involvement with the family but this service had a considerable knowledge of the circumstances which they provided to the Serious Case Review and it has already appeared at Section 1.4.

3.4. Police

Neither parent had come to the attention of the Police prior to the October 2012 injuries (though, of course, the Police became heavily involved in carrying out criminal investigations as a result of the injuries).

3.5. University Hospitals of Leicester NHS Trust (UHL)

NB: this IMR includes the Midwifery services.

There was no known contact with the father.

Mother was not known to the hospital prior to her first midwife booking appointment held on 31.8.11 at the GP surgery. An interpreter from the practice was used and the midwife took a full medical and social history, including questions about domestic violence and mental health. There was no history to arouse any concerns on these issues. The booking was somewhat late as mother had only recently registered with the GP (22.8.11).

The first hospital antenatal appointment took place on 19.9.11 during which an ultrasound scan was completed.

Subsequent routine antenatal appointments were completed (9.11.11, 7.12.11, 28.12.11, 25.1.12) at which no concerns were noted. Mother also had two further ultrasound scans (December and January) due to her low BMI but both scans were considered to be within normal limits.

The baby was born by normal delivery on 6.2.12 and translation services were used during the labour. Over the next two days on the postnatal ward mother and

baby checks were performed; feeding went well; again there were no concerns and mother and baby were discharged home on 8.2.12.

Community Midwifery follow-up took place in the form of home visits on 9.2.12, 13.2.13 and 16.2.12 with the midwife able to speak to mother in her own language. It was noted that mother and baby were bonding and assessments did not raise any concerns. At the last visit (16.2.12) a case-transfer sheet for the Health Visitors was completed.

Comment

There is evidence of good practice:

i. *appropriate use of interpreters during consultations*

ii. *questions regarding mental health, domestic violence, medical and social history; this is based on findings and recommendations from previous serious case reviews*

iii. *additional scans relating to mother's BMI.*

The Panel is satisfied that, based on a comprehensive report, key risk factors were appropriately considered antenatally and postnatally and none were identified; and therefore that there are no conclusions or recommendations to draw.

3.6. Leicester City Young People's Services (i.e. a Children's Centre)

The first attendance by mother and child at the Children's Centre was a Stay and Play session on 11.4.12. (These sessions are regularly attended by approximately 60 families; they focus on early learning; and staff are attentive to the needs of families attending and they observe both children and parents for any signs of isolation or depression in the parents and/or the child being unusually quiet or fractious.)

A second attendance, this time at a Baby Stay and Play (a smaller group of approximately 10 families) occurred a few days later.

Thereafter mother and baby attended baby massage twice (17.4.12 and 8.5.12); and Baby Stay and Play on three further occasions, the last one being in July; and also Health Visitor drop-in sessions. No issues or concerns were raised or identified; mother and baby presented as an "ordinary" family who were accessing services. Only attendance records were kept. (Individual records would only be kept for families who had been identified as vulnerable.) The family did not need to be discussed at the Liaison meetings between Children's Centre and Health staff.

Comment

It is noteworthy that at both the Baby Stay and Play and the baby massage, two practitioners were present throughout and both groups were consistently smaller than the Stay and Play. Therefore the staff could interact quite closely with the families; and in relation to baby massage they would have seen the child undressed. It is also relevant that the staff team is reflective of the diverse community locally and that several members of staff were able to communicate with mother in her own language.

In summary, mother and baby were seen 13 times by 5 different members of staff over a 5 month period and no issues of vulnerability or need arose and no concerns were identified. The fact that father did not attend is not unusual or perceived as significant.

In the light of a thorough and rigorous report, the Panel has debated whether anything more or anything different should have been offered; but the Panel is satisfied with the conclusion that there was nothing to indicate that the family needed anything more than universal services.

As a result of carrying out their review for this Serious Case Review, Early Years have identified some learning and internal action, but nothing specifically related to this case.

3.7. Health Visiting Service, Leicestershire Partnership Trust

The Health Visiting team received notification of mother's pregnancy on 31.8.11. The UHL Midwifery service routinely send a Prospective Parents form; but the Health Visitors do not offer universal antenatal contacts and there was no identified need to make such a contact.

A birth notification was received by the Health Visitors on 9.2.12 following the baby's birth on 6.2.12 and the Apgar score (a screening assessment tool) indicated the baby was healthy.

The new birth visit was conducted on 21.2.12 (i.e. within the prescribed 10-14 days standard). Advice was given re: co-sleeping and overheating, and mother responded immediately.

Thereafter the baby was seen and weighed 7 times up to 30.8.12, including 3 home visits by a Health Visitor and Community Nursery Nurse. The baby was consistently seen naked for weighing, she was gaining weight appropriately and thriving; attaining expected developmental milestones; and showed no signs of risk or injury. Taking account of cultural needs, mother was advised about a

vegetarian diet and weaning. From observations, there appeared to be good responses from the baby, i.e. active and alert; and from mother's reports there appeared to be good mother/child interaction, i.e. vocalising, smiling, etc. Mother presented as concerned, loving and caring towards the baby.

Overall, mother engaged well with the Health Visitors, attending all the arranged appointments, not cancelling or rearranging any. She was proactive in attending the Child Health Clinic and was seen to immediately act upon advice provided. Whilst Health Visitors had no difficulties in understanding mother's English, one of the Health Visitors spoke fluent Punjabi and other members of the team also spoke closely allied languages with the mother. There is evidence of cultural sensitivity both in communication and in advice; and there is no evidence of any communication difficulties or misunderstandings.

The main focus of the Health Visiting Service's involvement appears at Section 4; and two single agency recommendations are made at Section 7.

3.8. GP Service - at the time Leicester City Primary Care Trust (up to 31.3.13); now NHS England (from 1.4.13)

Mother registered with a GP practice on 18.5.11 and had consultations with a GP on 15th June and 7th July. Probably based on moving house, she then registered with a different GP practice on 22.8.11 and had a consultation with a Practice Nurse the following day, querying whether she might be pregnant.

After the pregnancy was confirmed and mother had seen a midwife and attended a hospital appointment, the GP saw both parents regarding their haemoglobin status, but subsequent blood tests revealed no concerns.

The baby was first seen by a GP on 21.3.12 for her 6-week surveillance check. A GP noted two pinpoint vesicles likely to be due to heat rash and a prominent frenulum, i.e. "tongue tie", for which the baby was referred to a Community Paediatrician for assessment. The rest of the examination was normal.

Mother then saw a Practice Nurse for a routine postnatal assessment; and the baby subsequently had three routine immunisations (April and June 2012).

The outcome of the Community Paediatric consultation was that the tongue tie was mild and should be reviewed in one year.

Father saw the GP once for his own health in August 2012.

The Individual Management Report makes one single-agency recommendation which appears at Section 7.

3.9. Nil Returns

- East Midlands Ambulance Service
- NHS Direct
- The CAF Team
- 13 to 19 Services in Leicester City Council
- NSPCC
- Leicester City Council Admissions or School Transport services
- Adult Social Care services
- Probation
- CAFCASS
- Leicester City Council ONE system (Education system)
- The clinical system (Adastra) and the out of hours service Central Nottinghamshire Clinical Services Ltd., providing the out of hours GP Service for Leicester, Leicestershire and Rutland
- Youth Offending Service

4. KEY PRACTICE EPISODES

This section is based on three very comprehensive and detailed reports, i.e. GP Services, Health Visiting and Health Overview; and I am very grateful to the respective authors for their detailed text including commentary and analysis; and for their series of interviews with the professionals.

Key Practice Episode 1

At 11.15am on 30.8.12 mother brought the baby to a "drop-in" Child Health Clinic for a consultation with a Health Visitor.

Comment

NB: Drop-in clinics allow parents to choose the date and time they attend a clinic and therefore Health Visitors have to respond to a wide variety of health and routine developmental issues. The clinic is very busy, i.e. often 30-40 families seen in a 2-hour period.

The level of staffing on 30.8.12 within the Child Health Clinic was considered good by the LPT HV IMR Author and consisted of two qualified Health Visitors, one Nursery Nurse and a Student Health Visitor (who was due to complete the Health Visiting course in September 2012).

Mother reported that the child had a recent history of a high temperature and had been reluctant to feed for the preceding two days. Mother presented as a concerned parent and was seen to handle the baby appropriately and talk to her while undressing her.

Mother drew the Health Visitor's attention to blue rash/marks/spots and red blotches on the baby's back; and the history reported by mother suggested an illness episode.

The examining Health Visitor requested a second opinion from her colleague Health Visitor and the two Health Visitors separately examined the baby naked. She was seen to be able to sit supported with a straight back, was able to bear weight and was mobile by rolling.

Having studied the marks/rash/blotches, both Health Visitors were uncertain what they were; but they considered that the marks may be associated with the history of illness and in their professional judgement the baby needed an urgent medical review.

Comment

> *The Health Visitors did not consider non-accidental injury as a differential diagnosis; they accepted mother's self-reported explanation at face value; and it appears that they did not discuss other possible causes.*
>
> *The descriptions of the baby sitting with a straight back, bearing weight, rolling over, smiling, etc. with no signs of distress do not present the baby as a child who was acutely unwell.*

The Student Health Visitor who was also present at the clinic was brought over to see the baby (as a learning opportunity) and she was not given the history of ill health; but she did consider non-accidental injury as a possible explanation; and she communicated this to one of the Health Visitors at the end of the clinic.

One of the Health Visitors then rang the GP surgery seeking an urgent medical appointment (which was offered) on the basis of the child being unwell.

As the Health Visiting team do not have access to SystmOne health records when they are working in a Child Health Clinic, consultations are recorded on a paper Child and Family consultation record (comprising a top copy and a carbon copy). The carbon copy is placed in the personal child health record, i.e. "the Red Book". The record of the consultation is documented onto the child's SystmOne record within 24 hours. This process was carried out by the Health Visitor in this instance; and therefore the mother took the Red Book to the GP appointment and this contained the carbon copy of the record describing and locating the marks.

However, there is no record of the fact that a second opinion was sought from a Health Visitor colleague, nor of the opinion itself; and a body map was not completed.

There were two options to do so, ie. a paper body map and/or the body map within SystmOne.

Comment

In interview the Health Visitor states that paper body maps were not available; but the IMR Author states that carbon copy body maps had been provided to the Health Visitors and the School Nurses since 2011; and the Health Visitor was unaware that carbon copy body map pads are available in clinic settings.

It is possible that a combination of the following factors came into play:

- *it was near the end of the clinic time when the room had to be vacated*
- *there were other children and parents to see*
- *if the baby was ill, the GP appointment was urgent*
- *the GP surgery was not open for much longer (i.e. closed in the afternoon)*

Nevertheless, the Health Visitor should have spoken to the GP; and this episode represents significant missed opportunities in (a) considering the possibility of non-accidental injury, and (b) making a body map record.

National guidance and LSCB procedures state that any bruising seen with variation in colour may possibly indicate injuries caused at different times. Bruising in a child who is not independently mobile should be suspected as non-accidental unless there is evidence or an adequate explanation is provided [NICE Clinical Guidance 89, 2009, LLR LSCB 1.3(4)].

A Health Visitor entry on the Family and Consultation Record reports that the baby was to be reviewed in 2 weeks; but the baby was not brought back to clinic and it appears that no system was in place to follow this up. A recommendation has been made to address this issue..

Key Practice Episode 2

As requested by the Health Visitor, the GP did see the child at the surgery shortly after noon on 30.8.12, with the mother having come straight from the clinic and retaining the Red Book. The Health Visitor had not spoken directly with the GP but had communicated through a receptionist. Obviously, as described above in Key Practice Episode 1, the message conveyed that the child had a rash and was unwell, but no safeguarding concerns were raised.

The GP recorded that the baby had a slight cold and “blue marks on her back” (using inverted commas). Also in the records is the statement that mother had noticed the marks earlier that day and they had started as red and then turned blue.

The GP did consider non-accidental injury and asked the mother some further questions, i.e. any concerns with her husband, who else had contact, etc. No concerns emerged from mother's answers. The GP also recorded that the baby looked well and he described the marks as bluish elliptical lesions on the baby's back on the mid-line and both sides of the vertebral column. He recorded "Diagnosis ???, ??? bruises".

<u>Comment</u>

In interview the GP noted that mother was relaxed, smiling, well dressed and nicely spoken; and these factors reassured him; together with his observation that the baby was happy, smiling and interactive.

According to GMC and NICE guidelines and also the LLRSCB procedures, the GP should have sought advice from a colleague, a Named Doctor, or the Paediatrician on call; and then should have considered referring to Children's Social Care.

In interview the GP accepts that he made an error of judgement in doing none of these things. He went on to suggest that he had not seen a Child Protection case in 20 years of general practice; and he found it difficult to believe that anyone would harm a child.

<u>Key Practice Episode 3</u>

The GP asked mother to bring the child back to surgery for a review on 4.9.12 (i.e. 5 days later) at which point he reported that he may consider a referral to Safeguarding Paediatricians.

<u>Comment</u>

As it appears that the GP was considering non-accidental injury (see above) this is a flawed response; whilst the colouring and aging of bruises require expert medical opinion and all safeguarding medical examinations are carried out by experienced paediatricians, the GP should not make a direct referral to paediatricians. A referral should be made to Children's Social Care and thus Community Paediatricians would become involved as part of the safeguarding process.

<u>Key Practice Episode 4</u>

As described in KPE1, the Student Health Visitor came over to see the baby in the clinic, primarily as a learning opportunity. Whilst not being provided with the history of the baby's temperature and illness, the Student Health Visitor asked one of the two Health Visitors who had examined the child to explain the decision to arrange a GP consultation; and she also enquired whether a safeguarding referral was required. According to the

Student Health Visitor, the examining Health Visitor's response was "She didn't know what it was and it needed a GP review".

Comment

From a systems perspective, does this denote some hierarchical thinking in two directions, i.e. the Health Visitor deferring to the GP? We now know that the GP claims never to have handled a Child Protection case – see KPE2 above; and the Student Health Visitor deferring to the Health Visitor when there is no evidence that the Health Visitor reconsidered the possibility of this being a safeguarding issue.

Key Practice Episode 5

On 31.8.12 the Student Health Visitor had a planned meeting with her Practice Teacher (a qualified Health Visitor with an Education qualification, supporting the clinic training of Student health visitors). In interview for this Serious Case Review the Student Health Visitor reports that she reflected on the clinic attendance the previous day and asked the Practice Teacher whether a safeguarding referral should have been made. Reportedly, the Practice Teacher said "A safeguarding referral would have been the right course of action". However, in interview for this Serious Case Review the Practice Teacher cannot recall this discussion and, although stating that she would have documented in the Student record any specific action that was required, the Student records (a paper folder) cannot be found.

Comment

This episode represents a critical missed opportunity for intervention:

- *the student Health Visitor has raised concerns and the Practice Teacher has confirmed that a safeguarding referral would have been appropriate*
- *the current and actual safeguarding of a child must override reflective discussion*
- *neither the Practice Teacher nor the Student Health Visitor went back to challenge the examining Health Visitor or to escalate their concerns*
- *it is totally unsatisfactory that the Practice Teacher "cannot remember" and that records cannot be located.*

The Student Health Visitor is a registered nurse who was in the last semester of her health visiting training. She had Nursing & Midwifery Council (NMC) registration and as a qualified nurse is expected to abide by The Code: Standards of conduct, performance and ethics for nurses and midwives (NMC 2008) which states:

"As a professional you are personally accountable for actions and omissions in your professional practice" and "must act without delay if you believe that you, a colleague or anyone else may be putting someone at risk".

These responsibilities and requirements apply to all qualified nursing staff.

Key Practice Episode 6

Also on 31.8.12 (late pm) the Health Visitor contacted the GP to hear of the outcome of the GP consultation the previous day. The GP described the marks as bruises and said that he had considered non accidental injury; but that he wanted to review the marks and that he had requested the mother to bring the baby back on 4.9.12.

Comment

This is now the second challenge to the Health Visitor (i.e. firstly from the Student Health Visitor at the end of clinic and now the GP using the word "bruises"). Therefore at this point a referral to Children's Social Care should have been made as per national and local guidance. To achieve this, ideally there should have been an agreed course of action between the GP and the Health Visitor; but, if not, the Health Visitor could/should have acted alone and independently.

The Health Visitor accepted and did not challenge the GP's view and decision and thus they unwittingly colluded with a fixed focus, referred to by Reder (1993)[3] as closed professional system. Neither did this telephone call trigger the Health Visitor or GP to contact the Named Nurse/Doctor for Safeguarding for advice. Both options would have been highly desirable.

Again, it is likely that the hierarchical dynamic is being played out here (as in KPE4), alongside the rule of optimism.

Key Practice Episode 7

The mother did not bring the child back to the surgery on 4.9.12 as the GP had requested in his consultation on 30.8.12; and there was no reply to a phone call to the mother. Therefore the Health Visitor who had examined the child at the clinic was contacted to inform her of this failed appointment and she prioritised this situation and visited the family home within 40 mins. There the Health Visitor spoke to another occupant of the house in the absence of mother. The occupant stated that both parents had been out since the morning with the child. The Health Visitor left a message for the mother to contact the GP surgery. The Health Visitor duly reported back to the GP surgery (where mother had still not attended) and was informed that the surgery would continue to try to

[3] Reder Duncan Gray: Beyond Blame; Child Abuse Tragedies Revisited (1993)

make contact. This Health Visitor also continued to keep the family's Named Health Visitor informed.

Comment

This failed appointment taken together with the GP's original reference to bruises on 30.8.12 should have escalated his concerns to the point of making a referral to Children's Social Care.

Key Practice Episode 8

The GP was sufficiently concerned following another telephone call with the Health Visitor the following day (5.9.12) to ask the Practice Manager to call in at the family home on her way home from work; which she did on 7.9.12. When she called, two males were outside the family home and one was speaking to the father on a mobile phone; so the Practice Manager was able to speak to him and she asked him to make an appointment for the baby at the GP surgery. However, this request was not fulfilled, i.e. no appointment was made or consultation attended in the short-term.

Comment

Yet again there was no notion of escalation of concerns; incrementally this was now the second failed appointment. In interview, the GP acknowledged concern at the failed appointments but was still influenced by the positive presentations of mother and child (see KPE2).

Key Practice Episode 9

Three days later mother did bring the baby for a consultation on 10.9.12 (nb: 11 days later). On this occasion they saw another GP.

Comment

There is no explanation recorded for seeing another GP and no evidence of any communication between the two GPs before or after the consultation, though this examining doctor did read the electronic patient record which states that the reason behind reviewing the baby was because of suspected non-accidental injury.

On examination, there were no signs of the marks and therefore the GP did not suspect non-accidental injury.

Comment

In interview, this GP believes that if they had been bruises, there would still be some evidence/sign. However, it is now 11 days from the first observation on

30.8.12 and therefore highly likely that, as bruises, they would indeed have disappeared.

This should have heightened the suspicion that they were bruises, rather than lessened the suspicion.

The GP now realises that his clinical judgement was flawed.

Key Practice Episode 10

From the clinic appointment on 30.8.12 the Health Visitor had asked that mother bring the child back to clinic in 2 weeks (approximately 14.9.12). Mother did not do so. However, the family's Named Health Visitor had been informed of the 30.8.12 drop-in clinic attendance by the examining Health Visitor running that clinic.

Comment

From a systems perspective, there was no system in place within the corporate team to communicate when a child had attended/failed a review at a clinic, i.e. there is no system to ensure follow-up other than relying on parents to comply with advice. Individual Health Visitors who are Named Health Visitors will have their own system (eg. use of their diary) but when running clinics they are unlikely to be the family's Named Health Visitor. Nevertheless, the back-up was that the family's Named Health Visitor had been informed of the consultation and outcome.

Key Practice Episode 11

The original GP saw mother and child again on 17.9.12 by a requested appointment; and, again, there were no marks other than some dry skin; the baby seemed well. Similarly, a further GP consultation was arranged for 1.10.12 and again mother and baby seemed well. Advice was given to maintain contact with the Health Visitor.

Comment

The GP did not revisit his original assessment, consult with his GP colleague, or consider a referral to Children's Social Care at these points.

5. CONCLUSIONS

a. Good Practice

There is evidence of good practice and I give some examples below:

- It was good practice for the first examining Health Visitor to ask for a second opinion from her colleague Health Visitor.

- The urgent GP appointment arranged and fulfilled in the light of the mother's reported signs and symptoms of the condition of the baby; nb: illnesses in young children can change rapidly.
- The Student Health Visitor challenging the examining Health Visitor whether a safeguarding referral was required.
- The Student Health Visitor reflecting on this case in supervision with her Practice Teacher.
- The examining Health Visitor maintaining continuity, eg. phone calls with the GP surgery; and particularly visiting the home within 40 minutes of being notified by the GP surgery of mother's failed appointment there.
- The Health Visitor keeping the family's Named Health Visitor informed of developments.

b. Missed Opportunities

However, despite the good practice cited above, there was a series of missed opportunities; and, again, I give some examples:

- The Health Visitor who examined the baby in clinic on 30.8.12 did not consider non-accidental injury as a differential diagnosis and did not record the marks on a body map.
- The GP, having identified the possibility of non-accidental injury, failed to consult colleagues and/or make a referral to Children's Social Care on 30.8.12.
- The GP/Health Visitor telephone conversation of 31.8.12 failed to refocus and then escalate the concerns once the GP used the word bruises.
- Following the failed surgery appointment on 4 September and the family failing to rebook on 7 September, the GP again failed to escalate these concerns.
- The Student Health Visitor and her Practice Teacher not acting decisively when non-accidental injury was suspected and a referral to Children's Social Care was confirmed as the right course of action. They should have gone back to the examining Health Visitor; and either of them could have made a safeguarding referral themselves.
- No discussion between the two GPs before or after the 10.9.12 surgery consultation, nor later on 17.9.12.
- These missed opportunities reflect poor practice on the part of individual Health professionals rather than any systemic weakness.

c. Lack of Challenge or Escalation

There are some examples of missed opportunities for challenge and escalation:

- Health Visitor colleague to the examining Health Visitor in clinic on 30.8.12
- Health Visitor to GP on three occasions
- Practice Teacher
- Between the two GPs.

d. Distraction

The mother's report of the baby's illness at the clinic on 30.8.12 perhaps distracted the Health Visitors from considering physical injury as a differential diagnosis. The examining GP was distracted by the positive presentation by the mother, eg. well spoken, well dressed.

e. The voice of the child

The GP and the Health Visitor did listen to the mother in regard to the presentation of Baby Z on 30.8.12. However, within the Health IMRs provided, both the Health Visitors and the GPs at points did not consider Baby Z as an individual, but they were influenced by mother's presentation and self-reporting of information. They did not triangulate this with their direct observation of Baby Z. It is a fine line that professionals have to balance in relation to listening, observing and analysing information presented to them as they seek to keep the child in focus.

The LPT Health Visitor IMR report provides a picture of a child achieving her developmental milestones at key ages (6 weeks, 4 months and 7 months) The context of the interaction between mother and the baby was presented positively. The focus of key professionals centred on the mother's presentation and her self-reporting of information, while Baby Z became lost from focus. Present and observed, but effectively unseen by the professionals and thus not framed in the correct context, eg. a baby having presented with potential injuries. Both the Health Visitor and the GP did have a number of opportunities to re-evaluate their input into the family (revisiting professional thinking).

f. Training

This Serious Case Review has evidence that the GPs were up to date with their child protection training, i.e. they had attended Level 3 training for GPs in 2009, 2010 and 2012.

On a particular point, one GP has no recollection of being advised to refer to Children's Social Care during the GP training he received. However, the training records confirm that all Level 3 training reinforces that if there are child protection concerns, a referral to Children's Social Care should be made; a recommendation is made at Section 7 in relation to GP training.

Similarly, the IMR author for Health Visiting has established that all the Health Visitors involved in this case were up to date with their safeguarding training,

i.e. all had accessed training between 2011-2012. Additionally, they all had allocated peer safeguarding supervisors and regular safeguarding supervision arrangements.

g. Overview

There is no evidence to suggest that any other agency could or should have been involved with the family prior to 30.8.12 and there is no evidence to suggest that there was any apparent missed opportunity by any other agency.

Following the baby's urgent GP appointment on 30.8.12 the GP and the Health Visitor did communicate. This was good practice. However, in the series of missed opportunities described at Section 5b above, their communication failed to elicit a critical discussion and thus the required outcome of a referral to Children's Social Care was not considered.

There was a lack of professional curiosity and also a lack of triangulating information on the part of the Health Visitors, GPs and Practice Teacher.

6. WHAT LEARNING HAS TAKEN PLACE AS A RESULT OF THIS CASE

The IMR authors were asked to identify the evidence that actions have already taken place and that learning has been embedded in practice.

Children Centres

Learning Journals have been put in place to track children in Baby Stay and Play sessions.

Group Learning Journals have been put in place for Stay and Play sessions.

GP Services

PM2 of GP practice 1 has formally reported to the Designated Doctor for safeguarding that GP practice 1 have made the following changes:

- GPs will share SystmOne records with Health Visitors.
- Health Visitors will be invited to Practice meetings.
- All children with a Child Protection Plan will have an alert on their medical record.
- Any parent/carer about whom the GP has concerns, for example mental health, drug abuse, alcohol abuse, will have an alert on their medical record.
- All staff will have easy access to the LSCB website which is now accessible on each computer.
- All safeguarding cases will be discussed at GP practice meetings.

- The GPs have reported that they would seek advice on any other case they see where they have child protection concerns.

Health Visiting Service

- The safeguarding briefings have been sent out to staff on lessons learnt arising from the Serious Incident Process.
- There are practitioner performance reviews underway within the agency.

Additionally, it is evident that this case has had a huge impact on the Health community, and the author of the Health Overview Report has elaborated the following:

- As a result of this case LPT have informed staff to always consider non-accidental injury as a differential diagnosis in babies presenting with unusual marks. In addition, LPT Level 3 initial and update Safeguarding Children Training programmes emphasise the importance of recognising and responding to unexplained marks on non-mobile babies.
- LPT have informed Children Services staff of the requirement to record all instances when a second opinion is obtained from another health professional/colleague.
- As a result of this case LPT have advised Children Services staff to use body maps to record birth marks, bruises and unusual marks to babies and children. A5 body maps were introduced for use by Health Visitors in Leicester, Leicestershire and Rutland prior to 2003 as a result of a previous serious case review and these were inserted into both child health records and each individual child's red book. Body maps must be used by practitioners when recording clinical observations, as it allows the accurate recording of what a practitioner has specifically seen at a point in time (which can avoid misinterpretation at a later date) of physical symptoms, eg. 'marks', skin discolouration, skin conditions and medical presentations. Body maps inform decision-making and can be used as a foundation for discussions in supervision with Named or Designated Professionals
- Staff members working within the Health Visiting service have been informed within a briefing circulated in November 2012 of the importance of completing body maps to record birth marks, bruises and unusual marks. Staff have had to sign to indicate that they have read the briefing and a central database is held to verify the process that staff have signed.
- The Practice Teacher now records her meetings with Student Health Visitors electronically to minimise the risk of documents being lost.

- As a result of this case LPT have reinforced to staff that they can challenge the decisions of other health professionals.
- LPT are planning to review child health clinic systems as an outcome from this investigation.

7. RECOMMENDATIONS

Health Visiting Services

1. The health visiting service should conduct a review of the management and leadership of child health clinics and the use of scheduling processes to effectively manage high child health clinic attendance rates.
2. The health visiting service should develop a consistent system that ensures children who attend a child health clinic and require a follow-up appointment are provided with the follow-up appointment within the initial clinic setting. This system will identify children who then do not attend the follow-up appointment provided.
3. The Family, Young People and Children's Division should audit the use of body maps by FYPC staff.

GP Services

4. Leicester City CCG to develop guidance for the role of lead GP for safeguarding in each GP practice.

Health Overview

5. Leicester City CCG Safeguarding Team in partnership with Named Doctors will put a process in place to review and evaluate the impact of GP Level 3 training that can demonstrate improved outcomes in relation to GP knowledge in regard to safeguarding children.
6. LPT must ensure that all Practice Teachers should record meetings with De Montfort University Health Visiting Students electronically to ensure consistency in practice.

The Panel has not identified any multi-agency recommendations.

Questions for a review to consider

1. Each of the relevant agencies identified should identify key practice episodes from its point of view and should answer the following questions in relation to each episode identified:
   a) Why does the IMR author, the practitioner and/or manager think(s) those particular episode/events are important?
   b) How did the practitioner(s) see the situation **at the time** (as well as subsequently)?
   c) What did the practitioner(s) know at the time of the episode/event?
   d) What professional judgements/key decisions were made in response to the episode/event?
   e) On what knowledge, experience or information did the practitioner base these judgements/decisions on?
   f) What were the contextual factors that were present for the practitioner at the time? (Contextual factors might include, but may not be limited to:
      I. workload levels,
      II. levels of staffing/absence in the team,
      III. the quality of management oversight and supervision (of the family and of the worker[s]) in this case
      IV. the level of supervision received,
      V. the level of administrative support available,
      VI. the quality and availability of assessment and recording tools and systems,
      VII. the quality and availability of both agency procedural guidance and inter-agency procedural guidance,
      VIII. unmet training needs,
      IX. budgetary constraints and the allocation of resources
      X. the effects of organisational review and change.
   g) To what extent did those personal and professional contextual factors influence the judgements/decisions at the time?

2. In relation to the care of the child:
   a) What strengths did the agency/organisation identify?
   b) How well were these strengths recorded, expressed and reviewed?
   c) What concerns did the agency/organisation identify?
   d) How well were these concerns recorded, expressed and reviewed?
   e) How did the agency/organisation respond to these concerns?
   f) How effective was the response of the agency/organisation?

3. In relation to "hearing the voice of the child":
   a) How often was the child seen by the professionals involved?
   b) Was this frequently enough?
   c) In view of the ages of the child, was it possible to ascertain her views and feelings? If so, how were the child's views and feelings ascertained? How were her views and wishes recorded?
   d) Identify the adults who tried to speak on behalf of the child and who had important information to contribute. What evidence is there that these individuals were listened to?
   e) Provide detail on any instances where parents and carers prevented professionals from seeing and listening to the child

f) To what extent did practitioners focus on the needs of the parents? Might this focus on the parents have resulted in the implications for the child becoming overlooked?

4. In relation to Thresholds and Signposting:
   a) What were the needs and risks that were identified?
   b) Were these needs and risks reviewed and managed properly?
   c) What referrals were made (or should have been made) to relevant agencies/organisations on the basis of information known to your agency/organisation?
   d) Was the practice of "handover" of responsibility for the case between tems and/or agencies effective in this case?

5. In relation to the Mental Health needs of the family:
   a) Were any mental health needs assessed or identified?
   b) If so, what action was taken by your agency/organisation to address these needs?

6. In relation to substance misuse issues:
   a) How did your agency/organisation address this with the family?

7. In what ways were the families' cultural, linguistic, ethnic, religious and disability needs were taken into account?

8. Were inter and intra-agencies' policies and procedures followed in this case?

9. Was Government guidance followed in this case?

10. To what extent were the decisions, assessments and plans made by the agency/organisation in relation to members of the household, visitors and family robust enough to meet the family's needs?

11. To what extent was the exchange of information appropriate, sufficient and effective:
    a) within the agency/organisation?
    b) between the agency/organisation and other partner agencies/organisations?

12. To what extent was the standard of recording appropriate, sufficient and effective:
    a) within the agency/organisation
    b) between the agency/organisation and other partner agencies/organisations?

13. What recommendations can the agency/organisation make in the light of the facts and the outcome(s) in this case, in order to improve practice?

14. Give examples of good practice that took place in this case (over and above the high standard regularly required) that indicate sound intra and inter-agency working.

15. Please refer to any relevant research or lessons learned from other SCRs

Leicestershire Partnership NHS Trust (LPT)

Recommendation 1:

The health visiting service should conduct a review of the management and leadership of child health clinics and the use of scheduling processes to effectively manage high child health clinic attendance rates.

Aim / Outcome	What are the actions that need to take place	Leadership	Timescale
To ensure that child health clinics appropriately meet the needs of the caseload.	(a) Review of Child Health Clinics across the organisation to determine best practice facilitation of child health clinics.	LPT FYPC Divisional Director	Completed
	(b) To pilot suggested new Child Health Clinic processes.	LPT FYPC Divisional Director	31.03.2014

Leicestershire Partnership NHS Trust (LPT)

Recommendation 2:

The health visiting service should develop a consistent system that ensures that children who attend a child health clinic and require a follow-up appointment are provided with the follow-up appointment within the initial clinic setting. This system will identify children who then do not attend the follow-up appointment.

Aim / Outcome	What are the actions that need to take place	Leadership	Timescale
Develop consistent appointment systems across child health clinics that arrange follow-up child health clinic appointments and identifies children who do not attend.	a) Scoping of current child health clinic appointment systems to determine most effective appointment systems.	LPT FYPC Divisional Director /	Complete
	b) Agreed appointment system/s to be launched across health visiting service.	LPT FYPC Divisional Director /	Complete

Leicestershire Partnership NHS Trust (LPT)

Recommendation 3:

The Family, Young People and Children's Division (FYPC) should audit the use of body maps by FYPC staff.

Aim / Outcome	What are the actions that need to take place?	Leadership	Timescale
Consistency with the use of the body maps to record marks or injuries.	Develop a face to face audit of 50% of Health Visitors working in Leicester City.	LPT FYPC Divisional Director	31.03.2014

NHS England Leicestershire & Lincolnshire in conjunction with Leicester City Clinical Commissioning Group (CCG)

Recommendation 4:

Leicester City CCG and NHS ENGLAND Leicestershire & Lincolnshire to develop guidance for the role of Lead GP for child protection (safeguarding) in each GP Practice

Aim / Outcome	What are the actions that need to take place?	Leadership	Timescale
To improve the understanding of those GPs who act as Practice Lead GP for Safeguarding Children.	a) Guidance document developed that directs GP Safeguarding Children Leads in the role and responsibilities of the function.	Medical Director, Chair & Designated Doctor (Leicester City CCG)	Complete
	b) Consultation and agreement with relevant stake holders to take place by 31.03.2014.		31.03.2014
	c) Once guidance is agreed to be circulated to all GPs undertaking this role.		30.06.2014
	d) Specific training and development of the Lead GP should be offered to ensure full understanding of the role and responsibilities.		31.08.2014

NHS England Leicestershire & Lincolnshire in conjunction with Leicester City Clinical Commissioning Group

Recommendation 5:

Leicester City CCG hosted Safeguarding Team in partnership with Named Doctors should by end of September 2013 put a process in place to review and evaluate the impact of GP Level 3 training that can demonstrate improved outcomes in relation to GP knowledge in regard to safeguarding children.

Aim / Outcome	What are the actions that need to take place?	Leadership	Timescale
Assurance that GPs attending Level 3 training sessions can demonstrate improved outcomes in relation to GP knowledge in regard to safeguarding children.	Develop a system to obtain evidence 3 - 6 months post training from individual GPs as to how attending the Level 3 GP Safeguarding Children training has informed their practice.	Medical Director, Chair & Designated Doctor (Leicester City CCG)	Complete

Leicestershire Partnership NHS Trust (LPT)

Recommendation 6:

LPT must ensure that all Practice Teachers should record meetings with De Montfort University Health Visiting Students electronically to ensure consistency in practice

Aim / Outcome	What are the actions that need to take place	Leadership	Timescale
Continuity in recording all meetings with Student Health Visitors by LPT Practice Teachers.	a) A standard template for the recording of meetings should be implemented.	LPT FYPC Divisional Director & Postgraduate Dean (DMU)	Complete
	b) An audit to be undertaken to ensure the documents are embedded into practice.		31.12.2014