Norfolk Safeguarding Children Partnership

# Safeguarding Child Practice Review

# Child AJ

Final Overview Report

Report Independent Author: Paul Nicholls

## Contents

# 1. Introduction and background

### 1.1. Background to the Child Safeguarding Practice Review (CSPR)

This review concerns the death from head injuries in December 2019 of Child AJ, aged three months.

It was suspected that the injuries may have been inflicted by the child's parents. AJ was found to have numerous healing fractures at post-mortem and the case is subject to a full prosecution from the Crown Prosecution Service, at the time of writing.

There were concerns regarding the parents' ability to care for AJ, particularly as the mother had concealed the pregnancy. Concerns were raised at the time of birth regarding parental attachment and their ability to care for AJ and subsequently two referrals were made shortly after the birth.

A decision was made by the Norfolk Safeguarding Children Partnership Chair based on the recommendation from the NSCP's Safeguarding Practice Review Group (SPRG) to commission a Local Child Safeguarding Partnership Review. This followed the submission of a Rapid Review to the Child Safeguarding Practice Review Panel in January 2020, in line with guidance set out in *Working Together 2018*[1].

### 1.2 Terms of reference and methodology

An independent lead reviewer worked alongside a Review Group, composed of senior managers from the following agencies: -

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| Norfolk Safeguarding Children Partnership Business Manager |
| Strategic Improvement Adviser for Looked After Children and Care Leavers<br>Norfolk Children Services |
| Designated Doctor Norfolk Safeguarding – Norfolk & Waveney Clinical Commissioning Group |
| Deputy Named Nurse - Cambridgeshire Community Services, 0-19 Healthy Child Programme |
| Lead professional for Safeguarding Children and Adults - Queen Elizabeth Hospital, Norfolk |
| Detective Inspector – Norfolk Police |

Governance of the Review Group was provided by the Safeguarding Practice Review Group. The CSPR will consider the Norfolk Safeguarding Children Partnerships (NSPC) Thematic Learning Framework (see Appendix One).

### 1.3 The aim of this CSPR.

The aim of this CSPR was to:

- Identify opportunities to draw on what worked well and promote good practice and what could have gone better and learn from them.
- Identify any learning and resulting recommendations for action.
- Provide opportunities for practitioners to learn from their own and others' experience, building confidence and empowering effective safeguarding practice for the future.
- Encourage a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children.
- Make use of any relevant research and case evidence to inform the findings.

[1] Working Together. A guide to inter-agency working to safeguard and promote the welfare of children. HMG 2018

### 1.4 The timescale of the review

It was agreed that the timescale for the review would be from **December 2018,** to include the mother's pregnancy, to **20 December 2019**, the date of AJ's death. It was agreed that the timescale would also include any significant events outside of this period considered relevant.

### 1.5 Key themes for consideration

The Review Group identified the following key themes, which would form the basis for the investigations that inform the learning and recommendations in this report: -

- Was there sufficient parenting support and assessment considering the concealed/denied pregnancy and other factors such as adversity experienced by the parents in their childhood?
- Was the safety planning on discharge from hospital adequate to safeguard the child, taking into account complicating factors such as mother's health and the support of a family network?
- How robust are the referral process and management of non-mobile infants with bruising where there is reliance on medical opinion, particularly if there is a professional disagreement?
- Decision making, transfer of information and communication at the point of closure: how well were professionals able to monitor AJ's milestones?
- How well are the processes and purpose of a Rapid Network Meetings understood across the Partnership?

The learning review consulted with relevant senior practitioners; these replaced a multi-agency learning event which was cancelled due to Covid-19 restrictions.

It was agreed that this review would use **Signs of Safety methodology** when looking at each of the key themes. The key questions were: -

1. What went well?
2. What could have been better?
3. What is the learning for future cases?

### 1.6 Family Composition

The family members relevant to this review will be referred to as below. The child was three months at the time of her death; both parents were in their thirties.

| Family member | Description used in this report |
|---|---|
| Subject | Child AJ |
| Mother of AJ | Mother |
| Father of AJ | Father |
| Maternal Grandmother | MGM |
| Maternal Grandfather | MGF |
| Paternal Grandmother | PGM |
| Paternal Grandfather | PGF |

**1.7 Parallel investigations**.

There were two parallel investigations alongside this independent review:

1. Serious Incident - Root cause analysis and action plan. – Cambridgeshire Community Services, NHS Trust – Completed July 2020.
2. Norfolk Police Criminal Prosecution – Ongoing as of December 2020. Advice regarding this review was sought from Senior Officers at Norfolk Constabulary and considered by the Review Group.

**The parents of AJ were invited to discuss the contents of this report and put their comments forward but due to the timings of the court case this has not been possible. The opportunity is still open to the parents as we would still welcome their input.**

## Summary of key events and dates

### 2.1 Nov 2018

Mother presented at the Hospital Early Pregnancy Assessment Unit with appearance of incomplete miscarriage.

### 2.2 September 2019

Mother is admitted to hospital in advanced stages of labour. Both parents claim they were unaware of the pregnancy. (There is some evidence that indicates this may be untrue.)

AJ born at approximately 38 weeks gestation weighing 2.57 Kg (5lb 11 oz). The gestation period was estimated due to the pregnancy being concealed or denied [2] and the lack of ante-natal care.

Mother admitted to Intensive Care Unit (ICU) with sepsis and other complications including pneumonia. AJ admitted to Neo-Natal Intensive Care Unit (NICU) for infection screening.

Midwife makes a referral to the Children's Advice and Duty Service (CADS) following concerns regarding the concealed pregnancy, the parents' lack of ante-natal care and their behaviours regarding their pet dogs. This is initially allocated to Family Support (Early Help) but following a further call the following week and the midwife's escalation of concerns, the case is then allocated to Social Care for assessment.

Case allocated to a Social Worker and 45-day assessment process begins. Parents are reported as 'being annoyed' that Children's Services are involved.

Multi-agency discharge planning meeting on 25th September. Concerns noted for Social Work assessment and dates arranged for joint visits by Health Visitor (HV) and Social Worker (SW). A teaching plan given to parents on discharge by a Nurse along with advice regarding pet safety and how to use a car seat, recently purchased by the parents.

[2] **A concealed pregnancy** is when a woman knows she is pregnant but does not tell any health professional; **or** when she tells another professional but conceals the fact that she is not accessing antenatal care; **or** when a pregnant woman tells another person or persons, and they conceal the fact from all health agencies. **A denied pregnancy** is when a woman is unaware of or unable to accept the existence of her pregnancy. Physical changes to the body may not be present or misconstrued; they may be intellectually aware of the pregnancy but continue to think, feel and behave as though they were not pregnant. In some cases, a woman may be in denial of her pregnancy because of mental illness, substance misuse or as a result of a history of loss of a child or children **(Spinelli, 2005**).

When AJ is six days old, Mother leaves hospital after declining a referral by Midwife for peri-natal mental health assessment. Parents visit AJ in NICU over the next two days. No other relatives are observed visiting.

HV and SW conduct first joint visit to the home for new birth visit.

SW visits home and offers further advice regarding AJ's safety around the family pets. During conversations father says he had a poor relationship with his mother and described emotional and financial abuse by her towards him.

Concerns noted about parents' attachment. HV makes referral for Parenting Support classes – Parents as First Teachers (PAFT) - delivered through the Children's Centre.

Community Midwife (CM) visits the family home and notes that AJ may be growth restricted due to time spent in NICU, but AJ is observed feeding well and gaining weight.

CM observes the behaviour of the family's boisterous dogs and offers safety advice to the parents to protect AJ.

**2.3 October 2019**

In early October, Family register AJ at West Locality medical centre (GP1).

Community Midwife visits home and observes a small scratch to AJs face. This was were also noted by the Health Visitor; it was felt that this was caused by baby's fingernails. HV shares concerns with SW regarding the boisterous dogs. SW informs HV that Social Care are keeping the case open.

Mother reported to HV that she had taken AJ to the Doctor following a cold and was made to feel she had overreacted. Note – There is no record of any such visit in the GP1 records.

CM visits home and observes a scab on AJ's nose which is flagged to the Duty HV. Around the same time the SW raises further concerns about the family's continued focus on their pets and speaks to HV.

CM hands over to Duty Health Visitor. AJ weighs 6lb 5oz

SW case supervision results in request for a Rapid Network Meeting[3] (RNM) to include maternal grandparents. A meeting is arranged which coincides with a previously booked meeting by the HV to weigh AJ; this meeting becomes the Rapid Network Meeting. The allocated HV is on holiday, so the Assistant Practitioner attends. She was unaware prior to the meeting that it would now be a Rapid Network Meeting.

**Rapid Network meeting:** attendees are AJ's parents, Maternal Grandparents, Social Worker (Chair) and Assistant Practitioner from the Health Visiting team. Small scratches to AJ's left eye and nostril noted; parents say they are self-inflicted. Also seen is a bruise on AJ's right cheek; parents say was caused by a borrowed car seat, which is too big for AJ.

[3] In Norfolk, a Rapid Network Meeting (RNM) must take place within 20 days of a Social Work assessment starting and will inform the outcome of the assessment, which must be completed within 45 days. Rapid Network Meetings are for cases which meet the threshold for Child in Need or Child Protection.

Parents said they now have a smaller car seat given to them by the Maternal Grandparents. Parents advised by SW to visit GP1 with reference to the injuries to non-mobile babies' protocol. Father recorded as being defensive and angry.

Assistant Practitioner makes GP1 appointment for the following day.

GP1 examines AJ with both parents present and records two bruises, one to the right cheek and one above the ear. The parents say these have been caused by the old car seat strap and that the car seat has been replaced by a more suitable, smaller version. They show the old car seat.

In line with the Norfolk protocol for injuries to non-mobile infants, GP1 refers the case to the on-call paediatrician at the hospital. Parents attend the same day.

The Consultant Paediatrician (CP) examines AJ with parents present. Two junior doctors and a nurse are also observing the examination as part of their training. The parents explained about the old ill-fitting car seat and produce it as evidence. Bilateral bruises were identified to AJ's cheek and behind the ear, some of which were observed to align with the car seat strap.

A Senior Paediatrician is consulted by the CP for further advice without the other doctors being present, but the Senior Paediatrician does not examine AJ or the car seat. A decision is made that there is no need for a skeletal survey and the parents' explanations are plausible.

AJ allowed home following the examination. The Nurse gives advice to parents regarding use of the car seat and the Social Worker is informed of the outcome by phone.

The following day, AJ attends GP1 surgery for 6-week check. No further concerns were recorded, and AJ was not weighed as part of the visit. (It is not usual procedure to weigh babies as part of a 6-week check, although some GP surgeries do.)

At the end of October, the Health Visitor visits the family home. The visit to hospital is discussed and father's remarks indicate to the HV that he has a limited understanding of child development and the importance of nurturing babies.

HV offers advice to the father and refers parents to Children's Centre for parenting support (emotional needs and developmental capacity).

Parents take AJ to GP surgery for white spots on her nose, diagnosed as a form of dermatitis; medication given.

**2.4 November 2019**

Early November, HV home visit for 6-8-week assessment. No major concerns recorded, AJ's weight is on track (3.44kg, 7lb 9 oz) and in line with centiles.

Parents engage in reflective conversation about parenthood. Father refers to his childhood and told the Health Visitor he experienced abuse and witnessed domestic violence. He said he did not have a good relationship with his parents and wants to be a better parent to AJ.

The care pathway recorded as universal partnership plus i.e., more than one professional involved with the family; the SW assessment is still ongoing. HV next visit booked with the family for end of November.

On or around 10th November, **the family move home (to North Norfolk locality),** after father gets new job in the agricultural industry. No mention was made to GP, Social Worker, or the Health Visitor of the impending move.

Mid November: AJ and father attend GP1 for 8-week immunisations. AJ appeared fit and well. AJ's father did not mention to anyone at the GP surgery that the family had moved to a new house, which was unusual.

SW recorded, prior to move, that AJ was 'well loved and cared for….and not assessed to be at risk of any harm' and was considering closing the case.

On 19th November, the Social Worker contacts father to say they are closing the case. He informs her they have moved to a new house.

The HV receives a call from father in 3rd week of Nov to say they have moved to North locality. This comes as surprise to the HV, who had a meeting booked with them that week. He had talked about moving to a new house but had not indicated this was imminent or given any details.

The HV contacts the Duty HV in North locality to inform them of the move and that the family were subject to a SW assessment under S17, Child in Need.

The HV informed the duty team of the safeguarding marker on SystmOne[4] indicating previous safeguarding concerns. There was no further contact with the family by that HV.

End of November: case closed by Social Worker and closure letter sent to parents on 29/11.

Case recorded as Universal Family Support as there was now only one professional, the HV, involved with the family.

**2.5 December 2019**

Mother returns to work in the hospitality industry.

Family register with GP2 surgery during first week of December.

A meeting of three GPs at GP1 surgery: GP1 notices on SystmOne that the family have moved to a new address. This entry would have been added by the previous HV, after contacting the North locality duty manager.

GP1 contacts the GP Safeguarding Lead for Norfolk, who contacts Cambridgeshire Community Services (CCS) to get details of the new GP (GP2) and advises GP1 to contact the new Health Visitor (HV2).

GP1 contacts HV2 to ask at which surgery the family had registered. HV2 gives the details and the GP1 outlines previous concerns, in particular the referral to the Paediatrician in October. HV2 can see on SystmOne clear recording of previous safeguarding concerns.

GP1 alerts HV2 to the fact that AJ is now late for 12-week immunisations. HV2 agrees to contact family.

[4] SystmOne is a centrally hosted clinical computer system. It is used by healthcare professionals in the UK predominantly in primary care.

HV2 speaks to father by phone and makes an appointment to visit later that week and reminds father to make appointment with GP2 for immunisations. He does so.

HV2 is not aware that the case has been closed by Social Care and contacts the previous Social Care locality team to check. Informed the case is now closed.

Father cancels first appointment with HV2 that week due to alleged maternal grandfather illness. HV2 makes further appointment for the following week.

Second week in December: Practice Nurse at GP2 surgery administers primary vaccinations to AJ. AJ was not weighed or examined. Advice given to father regarding possible reactions to immunisations.

Father makes urgent calls to GP2 reporting 'reaction to immunisations': AJ's hands legs and arms are swollen, and AJ is heard 'screaming very loudly'. GP2 arranges for AJ to be seen that day. Father and AJ attend GP2 surgery – initially seen by Practice Nurse who notes swollen left hand and scratch on right eyelid; this is reviewed by GP2 who does not have concerns. Not weighed as part of the examination. Calpol and fluids prescribed.

A week later, AJ's mother taken to work by Father with AJ in the car. Later that evening emergency call received, and ambulance dispatched to the family home.

AJ taken to Norfolk and Norwich University Hospital (NNUH), before being transferred to Addenbrookes. Suspected non-accidental head injury. Section 47 enquiries commence.

Father alleges that sudden braking in his car had caused AJ's injuries.

AJ dies two days after presenting at hospital. Investigation handed to Norfolk Police major investigation team. Numerous healing fractures identified at post-mortem as well as being malnourished.

AJ weighed 6lb 9oz at death.

## 2. Changes to front line practice since December 2019.

- Norfolk pathway for CCS health professionals – injuries to non-mobile infant's protocol updated.
- NSCP has established protecting babies as a priority, which includes developing a Norfolk Concealed/Denied pregnancy policy.
- Ongoing development of a Norfolk Protecting Babies strategy following recommendations from the Norfolk AF Case review, published in September 2019.

## 3. Thematic Learning

**4.1 Was there sufficient parenting support and assessment considering the concealed/ denied pregnancy and other factors such as adversity experienced by the parents in their childhood?**

**Commentary** – AJ's parents have been described during this review in terms such as displaying odd or strange behaviours and not always telling the truth. This made working with them difficult and challenging for professionals. They did not have a diagnosed learning difficulty, but professionals had to spend a lot of time explaining clearly what was expected of them, often repeatedly. They said they wanted to be good parents but needed support to achieve this.

AJ's mother was described as 'traumatised' by the pregnancy, which was concealed or denied, and this led to professionals noticing a lack of attachment to AJ immediately after the birth.

AJ's father was said to have little understanding of child development or the need to nurture infants and often referred to the baby in the same terms as he would the animals he worked with.

The parents' attachment to their pets was described as 'disproportionate' and professionals worked closely with them to ensure AJ was safe and they understood what was required of them.

AJ's father sometimes referred to abuse in his childhood and early adulthood, and his desire to be a better parent. When AJ was born, he did not have a close relationship with his family, and there was little involvement of the Paternal Grandparents in AJ's life.

In my view, allegations of previous abuse were never fully explored although it was considered as part of the Social Work assessment and considered to be a manageable risk. It was felt that there was a sufficient support network from maternal grandparents, maternal aunt, and family friends as protective factors.

**What went well?**

- There was a good engagement of a range of professionals, including Social Worker, Health Visitors and Midwives at the time of birth and in the first two months of AJ's life.
- There was an effective response to mother's and AJ's health issues following the birth; both spent time in Intensive Care and were visited by a range of professionals.
- Evidence of good Social Worker management oversight of the case following the birth, leading to a Rapid Network Meeting.

**What could have been better?**

- There is little evidence to support a robust parenting assessment after the birth and before discharge. Especially, taking into consideration the peri-natal mental health concerns, lack of attachment and concealment/denial of the pregnancy.
- There was insufficient understanding or assessment of how mother's previous miscarriage may have affected her mental health or may have led to the concealment or denial of the pregnancy.
- Father's allegations of previous abuse were shared with the Social Worker and Health Visitor, but this was considered to be a manageable risk. It was assumed that there were sufficient family networks to support the parents, without detailed exploration or enquiry.

**What is the learning for future cases?**

- The need for a detailed risk assessment of parenting capacity particularly where parenting engagement and mental health is a concern.
- Where the pregnancy in concealed or denied and mother is said to be 'traumatised' by the birth, a support package should be considered following the assessment.

**4.2 Was the safety planning on discharge from hospital adequate to safeguard the child, considering complicating factors such as mother's health and the support of a family network?**

**Commentary** – There was a discharge plan which included safety advice regarding use of a car seat from a nurse and planned joint home visits from the Health Visitor and the Social Worker.

The question is, was this sufficient? There were concerns regarding mother's mental health, parents' attachment and behaviors displayed whilst AJ was in hospital. These resulted in two referrals to Children's Services but there appeared to be little recognition of ongoing psychological support for mother, following a concealed/denied pregnancy.

It is not clear if professionals fully considered the lack of ante-natal care and a traumatic birth experience and how these may influence future parenting.

**What went well?**

- Good multi-agency involvement with Mother and AJ responding to their medical needs.
- Referral by Health visitor to Parents and First Teachers (PAFT) support within two weeks of the birth.

**What could have been better?**

- There was lack of professional curiosity around the family support network on leaving hospital; it was noted that there were few, if any, visits from family members. It was also noted in SW case file that 'Family relationships are not fully understood'.
- The hospital discharge and safety plans were not detailed and robust and there was no evidence of support for mother's physiological or psychological needs following a concealed/denied pregnancy and a traumatic birth.
- Little evidence of proactively trying to engage or fully understand family support networks, Maternal Grandparents in particular. Recorded in SW notes October 2019 as 'we need to get them more involved and aware of our worries'.

**What is the learning for future cases?**

- Greater understanding of family support networks before discharge where parental engagement and attachment is a concern. The use of a cultural genogram and a better understanding of mother's centrality in this, would have been an advantage.
- A greater understanding of the impact of concealed/denied pregnancy and the impact on bonding and parenting capacity.
- Research shows that when the baby is born there may be poor attachment and bonding, with the mother being psychologically unprepared to look after a new baby.

- The risks associated with concealed or denied pregnancies are well documented. Agencies need to have a shared understanding of these risks and their role in dealing with them. This should lead to psychological or psychiatric input being considered as part of any assessment or discharge plan.

**4.3 How robust are the referral process and management of non-mobile infants with bruising where there is reliance on medical opinion, particularly if there is a professional disagreement?**

**Commentary** – There is evidence to show good management oversight of the case leading to the need for a Rapid Network Meeting (RNM) in the third week of October. This RNM resulted in a referral to the GP following bruising on AJ's cheek, the referral should have gone directly to the on-call Consultant Pediatrician (CP), rather than via the GP, following the Norfolk protocol.

The CP sought advice from two junior doctor colleagues present during the examination, a nurse, and a Senior Pediatric colleague. There was some doubt about the parents' story regarding the car seat, but a decision was made to accept this. The nurse who was present was said to have a similar car seat for her child which was brought in to correlate the story told by parents, and gave some support to the parents' narrative of events.

With hindsight, the CP, who had recently been appointed as a Consultant, would have sought a more detailed visual examination of AJ from the senior colleague and involved the junior doctors in the discussions. This could have led to a full skeletal survey.

Importantly, the postmortem revealed that the majority of the healing fractures suffered by AJ were between 3 days and 4 weeks old, which means that these would not have been inflicted at the time of the Consultant Pediatrician examination in October, 8 weeks prior to AJ's death. AJ was also recorded as being malnourished. The family moved home 5 weeks before the death.

It was asked during this review, why was there not a strategy meeting called prior to the RNM? This was because there were deemed to be no non-accidental injuries recorded by the Social Worker, Health Visitor or Midwives prior to the bruising identified at RNM on 23rd October. It is worth noting that the Norfolk Injuries to Non-Mobile Babies Protocol states that a strategy meeting should be called when an injury is identified. In this case however, the referral from the Rapid Network Meeting to the on call Paediatrician was deemed sufficient. For future cases, a strategy meeting should be considered, as per the protocol

**What went well?**

- Management oversight of the case leading to a Rapid Network Meeting within 20 days of the Social Work assessment starting.
- Medical opinion sought immediately after RNM following identification of bruising to AJ's cheek.
- Quick response from GP referring to Paediatrician same day following examination at GP surgery.

**What could have been better?**

- The purpose of the Rapid Network Meeting should have been made clear to attendees, by the Social Worker and concerns referred directly to the on-call Paediatrician, not via the GP, as per the Norfolk protocol for injuries to non-mobile infants.
- The Consultant Paediatrician, relatively inexperienced in consultancy role, could have requested that the Senior Colleague examine AJ, rather than seek verbal assurance without an examination.
- The Junior Doctors and the Nurse, who were present at the examination, could have been part of the decision-making process with the Senior Paediatrician, when further advice was sought.

**What is the learning for future cases?**

- Greater understanding of the referral process after a Rapid Network Meeting across the partnership, particularly for bruising in non-mobile infants.
- There should be an opportunity for more junior and senior colleagues to consult and agree on diagnoses and decisions by senior colleagues, particularly if they have not been fully involved in the decision-making process.
- A strategy meeting should be considered as per the Norfolk protocol when an injury is identified to a non-mobile infant.

**4.4 Decision making, transfer of information and communication at the point of closure: how well were professionals able to monitor AJ's milestones?**

**Commentary** – The missed opportunities to monitor AJ's milestones in the last 6 weeks of life is the main area of concern in this review.

There was good involvement of professionals - Social Worker, Community Midwife, Health Visitors, GP - following AJ's birth weighing 2.57 Kg (5lb 11 oz) and going home at two weeks old.

AJ was described as a 'small baby' and 'growth restricted'; this was attributed to time spent in NICU immediately after birth, but she was meeting milestones and gaining weight (see below). It was recorded that the weight was 3.44kg (7lb 9 oz) on 4th November, one week prior to the family house move, when AJ was 8 weeks old.

**See Appendix Two for AJ's detailed weight chart mapped against expected growth centiles)**

The Social Work assessment was being completed within timescales and the Rapid Network meeting had worked effectively. There was some confusion about the purpose of the Rapid Network Meeting, which should have been clearly communicated to attendees.

A decision was made by Social Care in early November to close the case and the family informed by phone during the second week in November. It was then that father informed the Social Worker they had moved to a new house.

There is no doubt that the family's decision to move on or around 10th Nov was not communicated in advance to professionals, particularly to the Health Visitor who was due to visit and was not informed until two weeks after the move in a late-night call from AJ's father.

Father then visited the first GP surgery, a week after the move with AJ for 8-week immunisations but did not mention the move to the surgery then. It is not clear why the family did not communicate this, despite numerous opportunities to do so.

Once the HV was aware of the house move, the transfer of information on SystmOne was completed in appropriate timescales and handed over to the new HV locality. Handover was completed by the 25th November and contact was made with AJ's father within 10 working days as per operational policy. There was no 'face to face' contact with the family until early December, which meant that a vital 4 weeks had elapsed.

The first GP acted swiftly in early December after a GP practice safeguarding meeting, realising that SystmOne records showed a new address, alerting the new HV to the safeguarding concerns and that 12-week immunisations were due. This resulted in calls to the family from the HV to ensure appointments were booked with the new GP.

In the meantime, a decision was made to close the case to Social Care and a letter sent to the family at their new address on 29th November. The letter stated that the case was being closed with no mention of ongoing support from services. This was not communicated effectively to partners involved in the case, leading to some confusion whether the case was open or closed.

Once the new HV made contact and booked a home visit with the family, it was early December. The father then postponed this visit due to an alleged family illness, so the visit was delayed for a week. AJ would die a week later.

This means that following the Health Visitor call to the family home in the first week in November until AJ's death on 20th December, a 6-week period, there were only three face to face contacts with AJ; two were for immunisation visits to the GP1 at 8 weeks and GP2 at 13 weeks (a week late for 12-week immunisations).

The day after the second immunisations, when AJ was taken back to the GP2 Surgery for 'a reaction to the immunisations', AJ was examined, but not weighed as part of this examination, and no safeguarding concerns were recorded.

During this vital six-week period AJ lost weight, from 7lb 9oz on 4th November to 6lb 9oz at death. A Midwife estimated that AJ should have weighed around 9lbs at 12 weeks. It was during this period that the post-mortem revealed that the healing fractures would have occurred.

It is a major concern that there were three missed opportunities for a more detailed clinical examination of AJ during routine examinations. It is noted that AJ was not weighed at the 8-week and 13-week immunisations. Weighing of babies is not normally carried out at immunisation appointments in GP surgeries, however, so this is not unusual

**What went well?**

- Effective interventions by Midwife and Health Visitors ensure that milestones were monitored during first 8 weeks.
- Clear recording on SystmOne identified the previous safeguarding concerns on handover to the new Health Visitor.

- Good use of GP Safeguarding Lead to trace the family once GP records showed they had moved.
- Effective intervention by GP1 to contact new Health Visitor and alert to safeguarding concerns and the need for 12-week immunisation.
- New Health Visitor made every effort to visit the family once case had been transferred over.

**What could have been better?**

- AJ's clinical examination at GP2, which followed a suspected reaction to immunisations, in the days before her death, did not include her being weighed or plotted on a growth centile chart, which could have alerted professionals to her failure to gain weight.
- The case assessed under Section 17, Child in Need, and was closed by Social Care, but it was not clear that the family would still receive some ongoing support. This was not explained in the letter to the family who may have assumed there would be no further interventions.
- The new Health Visitor was unaware the case had been closed by Social Care on handover. Time was spent contacting the Social Care office in the West locality to establish the status of the case.
- Midwives record case records on a system called Badgernet and are unable to see records on SystmOne. This may hinder effective information sharing, especially where there are safeguarding concerns.
- There was a 6-week period with no face-to-face contact from Social Worker or Health Visitors. During this time AJ's weight dropped considerably and harm was caused.

**What is the learning for future cases?**

- Weighing and plotting on centile charts should form part of any thorough clinical examination of infants, particularly where there are known safeguarding concerns.
- The process for closing a case by Social Care and informing Health Visitors, GPs and other relevant professionals needs to be reviewed to ensure everyone is aware.
- The letters to family's informing them of case closure need to indicate that they will still be supported via universal services and details of that service where appropriate.

**4.5 How well are processes and purpose of a Rapid Network Meetings understood across the Partnership?**

**Commentary –** A Rapid Network Meeting (RNM) was held in late October, called by the Social Worker, during the assessment process. The timescales for RNMs during assessment are within the first 20 days, to allow the process to inform the outcome of the Social Care assessment.

RNMs are usually used for Child Protection Cases and fit within the framework - **Norfolk Vital Signs for Children, Family Network Approach (Feb 2019)** which states:

*It is a senior management expectation that all workers across the Social Work and Family Support services embed the Family Networking Approach and as part of this Family Network Meetings (FNMs), into their practice and offer to children and families, so that it becomes "business as usual" underpinning all our interventions.*

*Child Protection - FNMs [or Rapid Family Network Meetings] must be actively considered, promoted and implemented where possible in all stages of casework planning from initial referral, through the key stages of the assessment process,..*

The distinction was not always clear during this review, of the difference between a Family Network Meeting and a Rapid Network Meeting and which one happens when.

There was a concern raised by the Health Visitor that a pre-planned meeting on 23rd October had been used as an opportunity by the Social Worker to become an RNM, to meet their timescales. The Health Visitor was on holiday for that meeting, so an Assistant Practitioner colleague was asked to attend, and only became aware it was an RNM shortly before the meeting.

Having said that, the outcome was a positive one, with a referral to the GP and subsequently the Paediatrician, following the identification of bruising to AJ's cheek

**What went well?**

- Good identification of the need for a Rapid Network Meeting, including multi-agency involvement and Maternal Grandparents in the process.

**What could have been better?**

- Following the Rapid Network Meeting on 23rd October, the Social Worker should have referred directly to the on-call paediatrician rather than go via the GP as per Norfolk protocol for injuries to non-mobile infants.
- It was not made clear by the Social Worker that the meeting arranged on 23rd October was a Rapid Network Meeting. It should have been communicated so that the relevant qualified professionals could attend.
- The distinction between a Family Network Meeting and a Rapid Network Meeting and their purpose is not as clear as it should be for professionals.

**What is the learning for future cases?**

- Review of the Norfolk Vital Signs for Children, Family Network Approach (Feb 2019) and sharing of the guidance across the partnership.
- Clear guidance on who monitors the outcomes and next steps from Rapid Network Meetings.
- Ensure that staff attending RNMs are qualified and have the relevant experience, particularly where there are child protection concerns.

## 4. Joint learning between this review and the AF Serious Case Review

The focus of Norfolk's thematic Serious Case Review, Case AF (published January 2020), was 6 children from different families who suffered serious non- accidental head injuries. One child sadly died as a result of these injuries. Their injuries were sustained whilst in the care of their families.

Three serious case reviews had already been concluded and published in relation to three of the children. The review reflected on the established learning about these 3 cases and explored and analysed the services provided to the three other children.

The thematic review focussed on 7 research questions: -

1. How is the impact of parental vulnerabilities assessed and understood in relation to current and potential parental capacity? What services are needed to support vulnerable parents? Are they available?
2. How well is the impact of violence in the lives of children and adults assessed and understood?
3. What inhibits professional curiosity about injuries/reported accidental falls etc. involving young children and what may prevent professionals from following relevant policies/protocols/procedures? Is this due to professional deference?
4. How do current systems and processes support dynamic risk assessments that place the experience of young pre-verbal/pre-mobile child at the centre of the assessment process?
5. How well do multi-agency services understand the impact of organisational flux and high caseloads on the services provided to children- what can be done to recognise and mitigate this risk?
6. How do current safeguarding cultures across agencies support information exchange (supported by an active dialogue) rather than just information sharing? What needs to be in place to promote shared ownership of assessments and plans and support effective debate and challenge?
7. Do SCRs make a difference to the services provided to children and their families?

**Questions 1, 2, 4 and 6 were particularly relevant for this (AJ) review.**

## 5.1 Summary of the Key Learning from the AF review

Early involvement of trusted adults in the lives of children and adults builds a platform on which future trusted relationships can be built. Windows of opportunity should be harnessed, and services should be strengthened to increase capacity and gaps identified.

**Dynamic multi-agency risk assessments and risk sensible practice must be strengthened; the family and the multi-agency network should be fully engaged and the SOS model comprehensively embedded. – (See AJ Learning Theme 4.2)**

Respectful relationships should be promoted and facilitated across organisational hierarchies and the ownership of risk/decision making and collective problem-solving should be improved by routinely promoting information exchange, active dialogue, debate and challenge and through specific multi-agency forums, supervision and training.

**Breaking the trauma cycle - the cyclical nature of family patterns and difficulties needs to be understood. Awareness of Adverse Childhood Experiences (ACEs) and impact should be strengthened (about children and parenting capacity) and a shared multi-agency response delivered. – (See AJ Learning Theme 4.1)**

Safeguarding children is a human service, the emotional content of the work has a bearing on how children are safeguarded. The psychodynamic aspects (including how defences are constructed against the inherent anxiety) need greater attention and ways found to acknowledge the impact and mitigate the risks to enable the workforce to think and act.

The multi-agency safeguarding workforce protects children from harm every day and improves their outcomes. This workforce is the system's most precious resource, opportunities to demonstrate their value should be harnessed. Celebrate and promote good practice and what works well.

A just learning culture needs to be established to support the work force in identifying strengths and vulnerabilities so that learning and development can be strengthened.

A trauma informed approach is needed in order to respond to the needs of children and their parents, and the needs of staff.

Know your children – know your hot spots and prioritise – know your vulnerabilities. Courageous conversations are needed, this includes conversations with families, the front line, commissioners, inspectorates and political leaders.

Be conscious about the impact of organisational flux, inspections and SCRs and take steps to mitigate these risks.

Find ways to increase energy and commitment to build partnership working both at the front line and at a strategic level - be creative and take a long-term view. Develop joint priorities and a shared understanding/language and vision when responding to the learning from this review.

### 5.2 Outputs from the AF review relevant to this (AJ) review

A Norfolk Protecting Babies Strategy is in Development (as of December 2020).

The Protecting Babies Strategy has been written in response to increased risk during Covid-19 and based on learning from local and national SCRs/SPRs. The aim is to ensure that all babies are kept safe by identifying and addressing any risks posed by their parents/carers and supporting families to give children the best possible start in the first 24 months of life.

The strategy focusses on three key themes, these are:

- Non-Accidental Injuries to babies
- Pre-birth and concealed/denied pregnancy
- Safer Sleeping

One of the recommendations of this review is to ensure that the **learning from this review informs the Protecting Babies Strategy and subsequent action plan.**

## 6. Recommendations

6.1 The NSCP must develop better understanding of the impact of concealed/denied pregnancy and the impact on bonding and parenting capacity*. All concealed or denied pregnancies must be referred to Children's Advice and Duty Service and Social Work assessment; cases should be monitored to assess the extent of the issue, types of interventions and outcomes, including what services are put in place if cases close following the assessment.

** Research shows that when the baby is born there may be poor attachment and bonding, with the mother being psychologically unprepared to look after a new baby. This should lead to psychological or psychiatric input being considered as part of any assessment or discharge plan.*

6.2 There needs to be ringfenced reflective time for more junior practitioners to explore safeguarding issues in relation to diagnosis/decisions directly with senior Paediatric

Consultant colleagues, particularly if they have not been fully involved in the decision-making process.

6.3 Safeguarding concerns in infants under 12 months, documented in the clinical record, should prompt practitioners to consider more thorough clinical examinations, including monitoring of weight and plotting on centile chart. An action plan to embed the learning across relevant practitioners will be formulated following this review.

6.4 There needs to be effective and explicit communication between Social Care and partners involved with family when a case is closed. The decision to close a case by Social Care should be informed by the views of Health Visitors, GPs and other relevant professionals; the case closure process needs to be reviewed by Children's Services to ensure everyone is aware and in agreement. Children's Services also to review standard closure letters to parents to ensure they are more explicit about ongoing involvement with the child via other agencies e.g., Community Care.

6.5 Children's Services to review the terminology describing different types of Family Network or Rapid Review meeting to make them distinct and linked to the purpose of the meeting. The outcome of that review and any guidance developed to be shared with all partners.

6.6 The use of cultural genograms should form an integral part in Family Network Planning.

6.7 Ensure that the learning from this review is incorporated into an action plan and the Norfolk Protecting Babies Strategy and monitored by the NSCP.

## Appendix One: NSCB Thematic Learning Framework from SCRs

The NSCB Thematic Learning Framework has been developed to enable us to think about the recurring issues and barriers to effective working together. The framework was introduced to Board in December 2015 and has subsequently been tested with partners within Norfolk, through the Public Protection Forum (PPF), with the support of partnership board business managers, as well as nationally.

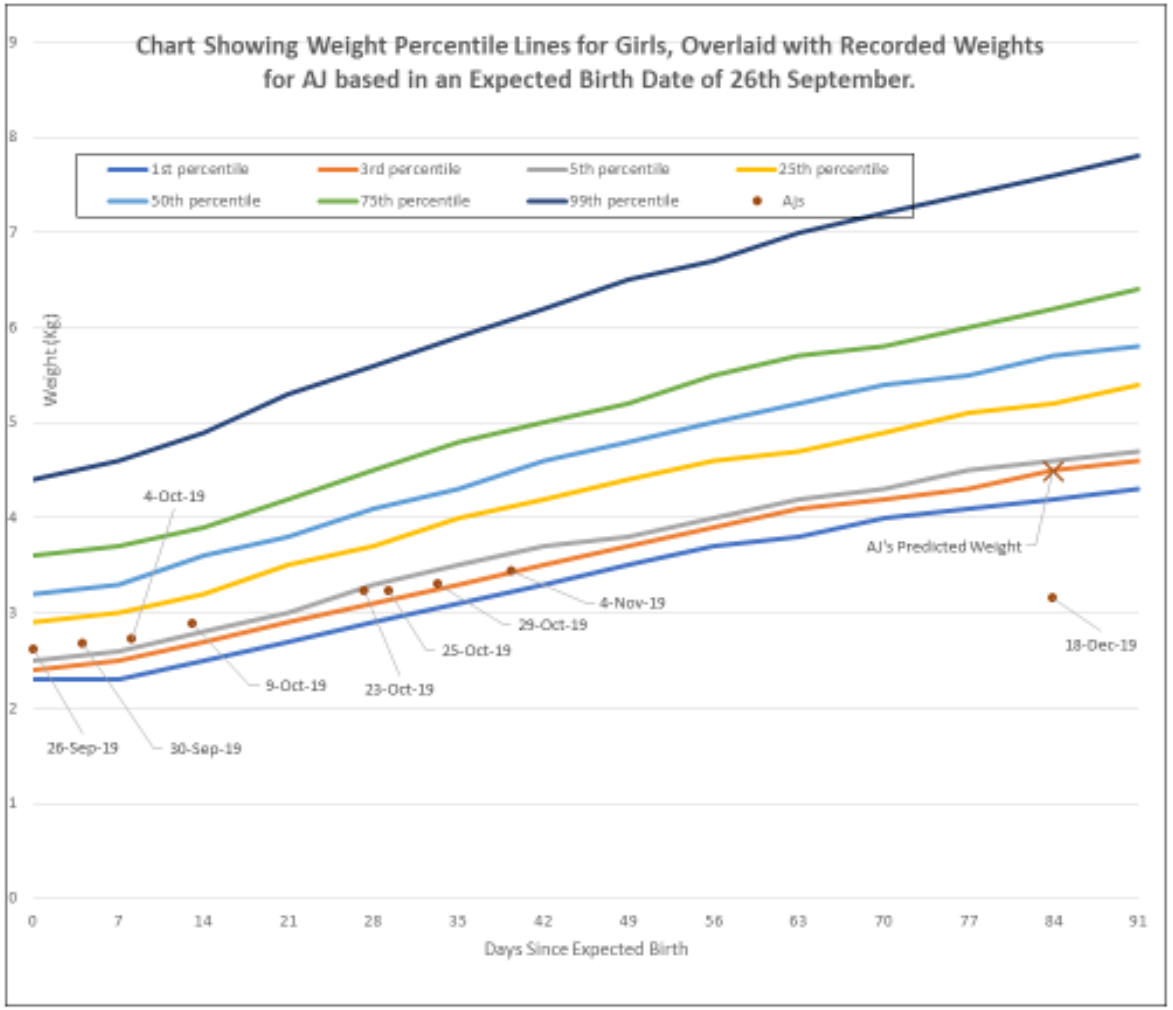

The thematic learning framework, focuses on four key learning areas:

1. **Professional curiosity** – how can the Board encourage and support appropriate curiosity with families, and between professionals?
2. **Information Sharing and Fora for discussion** – how can the Board ensure that we use opportunities for discussion effectively, include all relevant parties, act promptly and clearly; and share information well?
3. **Collaborative Working, Decision making and Planning** – how can the Board improve timely and collaborative planning and get strong and shared decisions?
4. **Leadership: Ownership, Accountability and Management Grip** – how does the Board give effective leadership and champion better safeguarding, locating clear accountability?

At the heart of all learning is the child or young person, and sitting underneath everything we do is the recognition that safeguarding requires people at all levels to manage risk and uncertainty

## Appendix Two: AJ's weight compared to growth centiles.

(Shows predicted weight on 18 December against actual weight)




AJ's Recorded Weights in Data Table format (below) and plotted alongside the World Health Organisation's Growth Lines (left) This Chart is based on Expected Date of Birth of 26/09/2019.

| Date | AJ's Weight (Kg) | AJ's Weight (LB) |
|---|---|---|
| 12-Sep-19 | 2.52 | 5.56 |
| 15-Sep-19 | 2.50 | 5.51 |
| 19-Sep-19 | 2.45 | 5.40 |
| 22-Sep-19 | 2.49 | 5.49 |
| 26-Sep-19 | 2.61 | 5.76 |
| 30-Sep-19 | 2.68 | 5.91 |
| 4-Oct-19 | 2.73 | 6.02 |
| 9-Oct-19 | 2.88 | 6.35 |
| 23-Oct-19 | 3.23 | 7.12 |
| 25-Oct-19 | 3.23 | 7.12 |
| 29-Oct-19 | 3.30 | 7.28 |
| 4-Nov-19 | 3.44 | 7.59 |
| 18-Dec-19 | 3.16 | 6.97 |

## Appendix Three: Implications of a Concealed or Denied Pregnancy

***(Adapted from Antenatal care: Routine care for the healthy pregnant woman, NICE, 2008)***

The implications of concealment and denial of pregnancy are wide-ranging. Concealment and denial can lead to a fatal outcome, regardless of the mother's intention.

Lack of antenatal care can mean that potential risks to mother and child may not be detected. The health and development of the baby during pregnancy and labour may not have been monitored or foetal abnormalities detected. It may also lead to inappropriate medical advice being given, such as potentially harmful medications prescribed by a medical practitioner unaware of the pregnancy e.g., some epilepsy medication.

Underlying medical conditions and obstetric problems will not be revealed if antenatal care is not sought. An unassisted delivery can be very dangerous for both mother and baby, due to complications that can occur during labour and the delivery. A midwife should be present at birth, whether in hospital or if giving birth at home.

Good practice in Antenatal care

- Midwives and GPs should care for women with an uncomplicated pregnancy, providing continuous care throughout. Obstetricians and specialist teams should be brought in where necessary.
- In the first contact with a health professional, a woman should be given information on folic acid supplements; food hygiene and avoiding food-acquired infections; lifestyle choices such as smoking cessation or drug use; and the risks and benefits of antenatal screening.
- The booking appointment with a midwife ideally should be around 10 weeks. This appointment should help the woman plan the pregnancy, offer some initial tests and take measurements to help determine any specific risks for the pregnancy. The woman should be given advice on nutritional supplements and benefits.
- Give information that is easily understood by all women, including those with additional needs, learning difficulties or where English is not their first language. Ensure the information is clear, consistent and backed up by current evidence.
- Remember to give a woman enough time to make decisions and respect her decisions even if they are contrary to your own views.
- Women should feel able to disclose problems or discuss sensitive issues with you. Be alert to the symptoms and signs of domestic violence and abuse.

**An implication of concealed or denied pregnancy could be a lack of willingness or ability to consider the baby's health needs, or lack of emotional bond with the child following birth**. It may indicate that the mother has immature coping styles or is simply unprepared for the challenges of looking after a new baby. In a case of a denied pregnancy, the effects of going into labour and giving birth can be traumatic.

Where concealment is a result of alcohol or substance misuse there can be risks for the child's health and development in utero as well as subsequently.

There may be implications for the mother revealing a pregnancy due to fear of the reaction of family members or members of the community; or because revealing the identity of the child's father may have consequences for the parents and the child