DSCB

Dorset Safeguarding Children Board

SERIOUS CASE REVIEW

S22

Independent Reviewer:

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INTRODUCTION

1. In June 2015, a four week old baby was taken to hospital where he was found to have bruising on his arm, two weeks later he was admitted with a number of injuries, including rib fractures and a fractured skull. A Finding of Fact hearing concluded that the later injuries were probably caused by his step-father. After a trial the step-father received a suspended sentence and the mother a community order. When the baby recovered he was placed with foster carers and later went to live with a close family member where he is progressing well, with no apparent long-term affects.

Method

2. The Dorset Safeguarding Children Board (DSCB) considered that the case met the criteria for a Serious Case Review and that there was learning to be gained from the case. The method used for this Review is known as the Partnership Learning Model, the key elements of which are the appointment of an Independent Reviewer and the participation of the practitioners who worked with the family in two Practitioner Events. The purpose of the events was to agree the facts of the case, why decisions and actions were taken or not taken at the time and identify any gaps in knowledge. As well as individual actions, practitioners shared information about the context of the work undertaken, for example workload, resource implications and policy directives and any other systemic factors which might have impacted on practice; the practitioner events were key in identifying the learning from this case.

3. The family were invited to meet with the Reviewer and share their views about the contact they had with professionals. These are included in the report.

4. The process was overseen by a Serious Case Review Group comprised of senior managers who had not had involvement with the case and who ensured the process was conducted properly. The final report was signed off by the Dorset Safeguarding Children Board (DSCB) prior to publication.

5. A Glossary of Terms is appended to explain the terminology.

Learning

6. The overall purpose of the Review is to learn from the case in order to make systems safer. This report sets out the facts of the case with an analysis of practice and the learning is presented thematically. It is the responsibility of the DSCB to ensure learning is disseminated and to evaluate how Serious Case Reviews influence and improve practice.

Review Period

7. In this case the baby's mother received her ante-natal care in a neighbouring authority; the family moved to Dorset when the baby was two weeks old. This Review covers the period from when the baby moved to Dorset to when he was admitted to hospital with injuries and removed from his parent's care, this is a timescale of four weeks.

FAMILY BACKGROUND

Anonymisation

8. The report is written with publication in mind and therefore some of the family's personal details have been summarised and names have been changed to protect privacy. The family members are:

    - Baby K
    - Ms J, his mother
    - Mr L, his step-father

Summary of Family History

9. Baby K was born in May 2015. After Baby K's injuries were diagnosed, further information about Ms J's background was sought from the authority from which she had moved. Reports indicate that Ms J had experienced a number of difficulties in her teenage years including bereavement and physical abuse; she ran away from home to live with friends and spent some time in care before moving in with a relative.

10. Baby K's mother was in her late teens when she became pregnant, the baby's father is some years older. Little was known during the Review about Ms J's relationship with Baby K's birth father, reports indicate the relationship ended soon after Ms J became pregnant.

11. At the time of the injuries there was limited information on the file about Mr L, Baby K's step-father. Reports indicate the couple met soon after Ms J became pregnant and she re-located to be with him. Mr L is a few years older than Ms J, he is a graduate, having completed his degree shortly after meeting Ms J and he was employed locally. The couple lived near Mr L's mother who was seen by professionals as a significant source of support for the couple.

KEY EVENTS

DATE	EVENT
May	Baby K born
21st May	Baby K, aged two weeks, and his mother and step-father move to Dorset. A referral was made from the previous authority requesting support for the family. The referral did not meet the threshold for intervention from Children's Social Care and support was requested from Action for Children.
5th June	The baby was seen by a Health Visitor and GP because of a breathing problem, the GP referred the baby to the children's ward at the local hospital where a paediatrician noticed the baby had bruising on his arm. The baby had an x-ray, nothing abnormal was detected. The paediatrician spoke to the baby's family and concluded the bruise was accidental. The paediatrician telephoned Children's Social Care, Out of Hours Team, who reported the case was not open to them. The baby was discharged home.
9th June	The Health Visitor telephoned Children's Social Care to make a referral. She was asked to put her concerns in writing.
12th June	The Health Visitor completed the referral form by hand and delivered it to the local office.
	There is some discrepancy about when the referral was logged. No action was taken by Children's Social Care.
17th June	The Health Visitor had a telephone conversation with the baby's step-father who reported the baby had a bruise on his forehead. The Health Visitor asked the step-father to bring the baby to the GP surgery where he was seen by the GP and immediately referred to a paediatrician. A Child Protection referral was made and the baby was admitted to hospital.
18th June	A Strategy Discussion was held in line with the Child Protection Procedures and, as the extent of the injuries came to light, the police used their Police Powers to prevent the baby being removed from hospital. The baby's mother and step- father were arrested, questioned and later released on police bail.
19th June	The baby's mother was asked to agree to his being accommodated under Section 20 of the Children Act 1989. The baby was placed with foster carers when he was well enough to leave hospital.
	The Review period ends.
	Care Proceedings were initiated in July and as part of the proceedings a Finding of Fact hearing concluded the baby's step-father was probably responsible for the injuries. Baby K now lives with his birth father.

THEMES FOR LEARNING

12. From the chronology of events and discussion with practitioners the themes for learning in this case have been identified as;

    - Referrals, Process and Practice
    - The Significance of Bruising in Non-Mobile Babies and Children
    - Child Protection and the Legal Framework

REFERRALS, PROCESS AND PRACTICE

13. Working Together to Safeguard Children and the Pan Dorset Multi-Agency Child Protection Procedures set out clearly the way in which concerns about children must be shared and how referrals to Children's Social Care are made. Working Together states that any professionals with concerns about a child's welfare should make a referral to Children's Social Care. If there are no obvious safeguarding concerns and a child and their family might benefit from Early Help services, the family can be referred for support. If the family may need support from more than one agency (eg housing, health, children's centre) there should be an inter-agency assessment such as the Common Assessment Framework, known as a CAF.

14. At the time this case was first referred to Children's Social Care, all new referrals to Dorset, regardless of status, were taken by one of the locality intake and assessment teams known as the Integrated Duty Teams (IDT). The information was recorded and a decision made about what response was appropriate; this may be a Child Protection investigation, known as a Section 47 investigation, an assessment by a team member, referral for support or maybe no action. All decisions following a referral had to be seen and signed off by a manager within 24 hours of the referral.

First Referral

15. In this case the first referral to Children's Social Care came when the baby and his mother first moved to Dorset from the neighbouring authority. The referral information came in the form of a document known as a Pre-CAF, an initial assessment designed to identify what support needs a child and family might have. Baby K and his mother were not well known to the referring authority as they had only lived there for a short period of time, Ms J having moved part way through her pregnancy to be with Mr L. The referral was brief, indicating that Ms J had been physically assaulted by her father "several weeks ago" and concluded that the only concern was that Baby K might be exposed to "physical aggression." Mr L was described as "very supportive" and Baby K was described as "appears to be loved by his family."

16. The document states that Children's Services (in the referring area) had closed the case as they had not identified any "personal safety issues."

17. Dorset received the referral and, on the basis of the pre-CAF, decided there was no role for Children's Social Care, that support for the family could be provided by a local voluntary agency and the case was passed on to Action for Children who ran a local Children's Centre which offered support including group work with young parents.

18. The Health Visitor had also been informed by Child Health that Baby K had moved to Dorset and she made a home visit when Baby K was 13 days old, a few days before the referral to Children's Social Care was received. During the visit Baby K appeared well but there were some concerns about his slow weight gain. The Health Visitor was able to gather some family history and observed Baby K with his mother and step-father.

19. The Health Visitor recognised that the family were vulnerable, for example Ms J was aged 17, the couple had only been together for a few months prior to Baby K's birth, Mr L was not Baby K's birth father and the couple had little family support. The Health Visitor noted a mixed picture about Ms J's parenting capacity, commenting both that she enjoyed being a mother but sometimes felt uncomfortable handling the baby.

    Ms J also indicated that she was unwilling to engage with the Children's Centre or a young parents group. The Health Visitor concluded that further assessment was required to determine the need for support.

20. The Health Visitor then made contact with the local midwifery service to find out if they had been informed about Baby K's move to Dorset, they had no information. The Health Visitor also contacted Children's Social Care, who had by this time received the referral from the neighbouring authority and were able to tell the Health Visitor that the case had been passed to Action for Children. The Health Visitor contacted Action for Children but the case had not yet been allocated; the Health Visitor hoped that despite her initial reluctance, Ms J could be encouraged to attend the local Children's Centre.

21. There was a delay of a few days before the case was allocated to the Action for Children outreach worker who contacted the referring authority for more information about Ms J and the family. Some information was shared during a phone call with a more detailed chronology being received by Action for Children a few weeks later, after Baby K has been seriously injured.

22. In this case events moved very quickly. Baby K was seen at the hospital with bruising and a fractured rib (not diagnosed at the time) just after the Action for Children worker had visited and before she had time to share information with the Health Visitor.

The Significance of Background History

23. Clearly Children's Social Care can't intervene in every case, finite resources have to be rationed and for this to work effectively, practitioners need to know which children need help. This knowledge requires professional judgement and based on what was

known at the time, the referral did not indicate any safeguarding concerns, the decision of Children's Social Care that the case did not meet the threshold for a formal assessment appears to be reasonable.

24. At that time Action for Children were part of the Integrated Duty Team and a conversation took place during which Action for Children agreed that a referral to their service was appropriate. There was little information on the pre-CAF on which the referring authority had decided there were "no personal safety issues;" the referral does acknowledge the family had only just moved to their area and were there for a very short time which might explain the lack of detail. The Action for Children worker acted properly in attempting to obtain more information from Ms J's home authority. She reports that a phone call to the referrer "made the case sound very straightforward."

25. Information about Baby K's mother which was collated after Baby K's injuries, showed that Ms J:
    - became pregnant at 16
    - the baby's father was significantly older
    - experienced the death of several close family members, including her mother
    - alleged physical abuse from more than one family member
    - ran away from home and spent some time in care
    - had been referred to the Child and Adolescent Mental Health Service (CAMHS)
    - met Mr L "on line" and had moved to Dorset to be with him before Baby K was born
    - had lived in two different local authority areas during her pregnancy before moving to Dorset shortly after Baby K's birth
    - had been known to Children's Social Care in her home authority for at least 7 years

26. Although we cannot know if Children's Social Care had carried out an assessment at the point of the first referral this would have changed the outcome for Baby K, this case provides a useful reminder about the relevance of a parent's background history in identifying any predisposing risk. Based on what was known at the time, the response to the first referral was timely and appropriate, however hindsight provides a valuable lesson. The background information, if it had been fully known at the time of the first referral, would have shown that there were a number factors in Ms J's history which are commonly associated with poor parenting capacity and risk of harm to a child.

27. For practitioners this raises the question about when and how to seek further information at the point of referral and in particular how the threshold for intervention by Children's Social Care is applied to a pregnant teenager.

Learning

- Whilst most referrals are accepted at face value, there will be times when professional judgement suggests a more probing response is indicated and further information sought before making a decision about appropriate action. For example when the referral concerns a teenage parent who is new to the area.

Second Referral

28. In early June, when Baby K was four weeks old, the Health Visitor, during a routine visit, noticed the baby had some breathing problems. She arranged for Baby K to be seen by the GP who referred him to the hospital paediatrician. It was during the medical examination at the hospital that Baby K was found to have some bruising on the inside of his arm.

29. The breathing problems were not found to be significant and Baby K was discharged home. When the Health Visitor was informed of the outcome of the examination and the presence of the bruising, she discussed the case with the paediatrician and was concerned that a referral had not made to Children's Social Care in line with the protocol about bruising in non-mobile babies. (See Theme Bruising in Non-Mobile Babies)

30. The Health Visitor already had some concerns about this family and was frustrated at the apparent lack of action from Children's Social Care, she reports that she felt she was "working blind" and that there was more information available which was not being shared.

31. The Health Visitor sought advice from her Safeguarding Advisor which led her to telephone Children's Social Care to make a referral. Children's Social Care asked the Health Visitor to put her concerns in writing once she had informed the family of her intention. The Health Visitor saw the family and put in a written referral three days later, she also telephoned Children's Social care to ensure they had received the information.

Response to the Health Visitor's referral

32. There is a difference of opinion between the agencies about the response to the Health Visitors concerns. Children's Social Care did not categorise the verbal referral as a Child Protection referral which would have required immediate action, or consider it in the context of the Protocol on Bruising and Injuries in non-mobile Children.

33. For Children's Social Care the information provided by the Health Visitor was not new. They had heard from the paediatrician about the bruising seen on Baby K and agreed with the paediatrician's view that it was accidental and there was no need for any further investigation. Children's Social Care were also aware that Action for Children were attempting to work with the family and that the Health Visitor was in regular contact with Baby K. For Children's Social Care there was no indication that there was a need for any further action.

34. Children's Social Care asked the Health Visitor to put her concerns in writing. The inter-agency referral procedure states that if a referral is not a Child Protection one, the parents must be told about the referral *before* it happens and the Health Visitor did this, handing in a written referral a few days later.

35. Although there is no record of a response to the Health Visitor's referral, two days after the written referral, Baby K was admitted to hospital where he was diagnosed with several injuries including a fractured skull. This led to a new referral and the immediate initiation of the Child Protection Procedures.

What can we learn from this?

36. It is concerning that there was no clear and timely response from a manager in Children's Social Care to a telephone call and a written a referral about a six week old baby with bruising. The manager should have seen the information and recorded a decision about what action to take. In this case the lack of clarity did not affect the outcome as events moved on very quickly and Baby K was admitted to hospital.

37. In discussing this case at the practitioner events, with hindsight there was an acknowledgement that the threshold for intervention from Children's Social Care had clearly been met because of the presence of the bruising. Even without the bruising, there was consensus among staff that there is value in multi-agency discussion and information sharing which can take place at any time.

Learning

- In this case that not all the information shared between the Health Visitor and Children's Social Care was recorded. If information sharing is to be effective in safeguarding children, it is important that information gathered over time by all agencies is recorded carefully and contributes to a picture being built up over time.

THE SIGNIFICANCE OF BRUISING IN NON-MOBILE BABIES

38. Bruising in babies and infants who are not crawling, cruising or walking (non-mobile) is rare and there is a wealth of research about its significance as a potential indicator of child abuse. The NICE guideline 'When to Suspect Child Maltreatment[1] states that bruising in any child 'not independently mobile' should prompt suspicion of maltreatment.

39. Although there is not always consensus among medical practitioners about the significance of statistics, there is also a general understanding among practitioners that bruising in babies can be considered sentinel events and are similar to sentinel injuries. These are defined as minor inflicted injuries/physical signs that are presented to physicians *before* the recognition that the child has been abused. Often this recognition comes later with the findings of a severe or catastrophic non-accidental injury. In one study these injuries were present in 25% of children subsequently diagnosed as abused.[2]

40. Subsequently most Local Safeguarding Children Boards in the UK have a multi-agency protocol which defines what action is to be taken if a non-mobile baby or child (for example a non-mobile child with a disability) is found to have a bruise.

41. In Dorset the Protocol known as the "Bruising and Injuries in non-mobile Children Protocol"[3] (for ease of reading referred to as the Bruising Protocol) was adopted in July 2012 as a result of learning from a Serious Case Review, known as S4.[4] In that case bruising was seen on a baby, by different professionals on more than one occasion, and the explanation given by parents was accepted. The baby was later subjected to life-changing injuries.

42. The Dorset Bruising Protocol requires that:

> *"all not independently mobile children with bruising or a burn or scald should be referred to Paediatrics AND to Children's Social Care "*

The Sequence of Events

43. Baby K was first referred to the paediatric department by his GP in June 2015 when he was four weeks old. The reason for the referral was the presence of intercostal recession, this is a medical condition, not uncommon in babies, which can indicate breathing difficulties. Both the GP and the Health Visitor had seen the baby undressed, neither had noticed the bruising on the baby's lower arm however, when the baby was examined at the hospital, the bruises were noticed.

[1] See: http://guidance.nice.org.uk/CG89

[2] Sheets LK et al Paediatrics 2013: 131(4)

[3] Bruising and Injuries in non mobile Children Protocol

[4] See Dorset Safeguarding Children Board, S4, published January 2014

44. The paediatrician was aware of the Bruising Protocol and considered it his responsibility to ascertain how the bruises had been caused. The paediatrician explored the circumstances of the bruises with Baby K's mother and step-father who gave an elaborate description of events which concluded that the baby's arm had become trapped in the handle of a Moses basket. The paediatrician asked to see the Moses basket and after careful thought, concluded the bruising had been caused accidentally.

The X-Ray

45. Because of the intercostal recession, the paediatrician referred Baby K for a chest x-ray. The written request for the x-ray did not mention the bruising as it was not seen as relevant to the medical diagnosis. The x-ray was seen by both a radiologist and the paediatrician, neither of whom noticed that Baby K had a broken rib. Several weeks later a medical examination of the baby identified the rib fracture which was observed to have been present at the same time as the bruises.

46. Fractures in babies can be hard to detect, because the bones are still soft and tend to bend rather than break, they are not easily observed on an x-ray. The key feature in this case however appears to be the lack of recognition of the potential significance of the bruises. The referral form to the radiologist did not mention the bruises which might have raised the possibility in the radiologist's mind to look for injuries, neither was it in the mind of the paediatrician who also reviewed the x-rays.

Professional Response to the Bruising

47. The paediatrician was thoughtful and pro-active in investigating the cause of the bruising and, in line with the Joint Protocol for Assessment of Bruising in a Child who is not independently mobile, flow chart 2[5] , carried out an assessment and liaised with Children's Social Care. The Flowchart then gives two options, either safeguarding concerns are confirmed or suspected or a medical cause for the bruising is identified. In this case neither of those options was found and the paediatrician decided the cause of the bruising was accidental.

48. In order to confirm his view, the paediatrician telephoned Children's Social Care (Out of Hours Team) to ask if the family were known. The response was that the case was not open to Children's Social Care and therefore the paediatrician concluded there was no need for further action.

49. Children's Social Care accepted the paediatrician's conclusion without question or challenge. He produced a report for Children's Social Care in order that there was a record of the incident.

[5] The on-line protocol includes four Flowcharts, Flowchart 2 is for medical practitioners in the safeguarding system.

50. Children's Social Care accepted too readily the paediatricians view and that the baby could be discharged from hospital. Whether the bruising had been caused accidentally is not the key issue. The actions taken by the paediatrician, whilst well motivated, suggests that he failed to understand the principle behind the protocol, that no single person or agency should decide if the nature of the bruising requires further multi-agency exploration and that, even if a bruise is considered to have been caused accidentally or by rough handling, further assessment is important.

51. This is because clinical experience and research on the significance of bruising in a non mobile child as a symptom of child abuse is clear. Marion Brandon et al summarise the findings:

> "*Because physical self-control and independent movement is very limited in young babies, it is extremely difficult for them to bruise themselves. Any bruising is likely to have come from an external source. The younger the baby the more serious should be the concerns about how and why even very tiny bruises on any part of the chid are caused. The explanation that a pre-mobile baby hurt themselves whilst in a cot needs to be scrutinised very carefully and treated with suspicion."*[6]

52. When a baby is found to have bruising, information sharing is vital and other agencies must be given the opportunity to contribute to multi-agency risk assessment. In this case the observations of other staff on the ward, who had seen Baby K and the interaction with his mother and step-father, and the observations of the GP and the Health Visitor about parental responses to the baby were not given consideration in the assessment of the injuries.

53. During the process of this Review, the ward staff reported "*being shocked that a four week old baby with bruises could be discharged*." Some staff had noticed behaviour from the baby's mother which alarmed them, for example her not wanting to stay on the ward with him overnight, her attitude to Baby K and some negative comments she made about him, some of which were recorded on the patient file. There was also some similar information on the patient file from the GP and Health Visitor.

54. Ward staff appeared reluctant to challenge a very experienced consultant paediatrician at a time when the ward was particularly busy. They also reported being reassured that the step-father's mother was helpful and was supporting the couple and that a home visit by a "social worker" was planned to take place a few days later; this was in fact the Action for Children outreach worker who did find out about the bruising but only because Baby K's mother mentioned it. The outreach worker did not see Baby K on that visit, he was out with a relative when she called, she asked to see the baby's sleeping arrangements and insisted she see Baby K on her next visit. In hindsight the information which the ward staff found reassuring was based on superficial and misleading facts.

[6] Marion Brandon et al, Child and Family Practitioners' understanding of Child Development: Lessons learnt from a small sample of Serious Case Reviews, University of East Anglia, 2011

55. To address some of the issues arising from this case safeguarding supervision was introduced for paediatric ward staff in the Summer of 2016. The agenda includes when to seek advice about safeguarding concerns, how and when to record social observations on patient files and the internal escalation policy.

Learning

- There is a wealth of information about the significance of bruising in non mobile babies and its links to abusive care which needs to be reflected in guidance and protocols.
- Professional challenge is a vital part of the safeguarding system and all staff, however senior and experienced, should be open to challenge. All staff should also be confident to raise their concerns with colleagues and know how to escalate if they consider their views are not being heard.
- In order to obtain a full picture of family functioning and the impact of parental care on a baby, it is important to record social observations and discuss their relevance when assessing risk.
- The decision about whether it is safe to discharge a baby should always be based on the main carer of the baby, any reassurances which suggest a reduction in risk should be carefully considered.

Reviewing the Bruising and Injuries in Non-Mobile Children Protocol

56. The Serious Case Review, known as S4, was published in January 2014 (the Report was completed in 2012, there was a delay in publication because of criminal proceedings.) It concerned a five month old baby who was admitted to hospital with life changing injuries inflicted by the baby's parent. There were a number of learning points from the Review some of which arose from the response to incidents of bruising which were observed by several different professionals on separate occasions.

57. One of the recommendations was:

> "*That the "Bruising, bleeding, fractures and possible injuries in children who are not independently mobile" protocol produced by health professionals is taken to the LSCB for endorsement so that it can be disseminated for use by all professionals in the inter-agency community, with clear guidance on the point of contact for professionals who have concerns*."

58. Despite his serious injuries, Baby K made a full physical recovery, however the professional practice fell short of that which the Bruising Protocol is intended to

promote. Discussion with the staff involved in the case indicates that they were aware of the Protocol; it was the way in which the protocol was interpreted which led to an opportunity being missed for a more robust intervention at the time when bruising was first observed.

59. This Review concludes that the Bruising Protocol is not explicit about either the significance of bruising in non mobile babies or the action to be taken when bruising is observed. The bruising protocol under the heading "Recommended Action" states that

> *"the guidance recognises that practitioner judgement and responsibility have to be exercised at all times, it errs on the side of safety by requiring that:*
>
> - *All not independently mobile children with bruising or a burn or scald should be referred to Paediatrics AND to Children's Social Care;*

It goes on to say:

- *For suspected injuries brought to the attention of medical practitioners there should be an appropriate examination and the completion of body maps. In infants (< 12 months of age) an appropriate examination would include undressing the infant.*
- *Records must be signed, timed, dated, accurate, comprehensive and contemporaneous.*

60. In this case there was ambiguity about both what constitutes a referral and what action should be taken in response. The GP and Health Visitor acted promptly in referring the baby to paediatrics; the Health Visitor also tried to refer the baby to Children's Social Care as described in paragraph 30 of this report. The paediatrician examined the baby and telephoned Children's Social Care but neither he nor the social worker defined this action as making a referral. The outcome of the conversation between the paediatrician and Children's Social Care was a note on the file from the paediatrician describing the bruising and his enquiries.

61. Comparing Dorset's protocol with some other LSCBs the differences can be seen in:

- how much prominence is given to the significance of bruising in non-mobile babies
- prescribing an explicit response

For example by remembering "that a bruise should never be interpreted in isolation" "requires an immediate referral to Children's Social Care, a detailed examination and that a bruise must always be assessed in the context of medical and social history, developmental stage and explanation given" and that "Children's Social Care will coordinate multi-professional information sharing and assessment." [7]

[7] See for example Greater Manchester Safeguarding Partnership, Bristol Safeguarding Children Board, Cambridgeshire LSCB

For the DSCB

- The DCSB should satisfy itself that the Bruising Protocol provides explicit, accessible guidance which is understood by all the professionals in the safeguarding system.

- In light of the findings of Serious Case Review S4, the DSCB will need to consider how to disseminate the learning from this SCR effectively in order that it reaches as many relevant child care practitioners as possible.

CHILD PROTECTION AND THE LEGAL FRAMEWORK

62. Nineteen days after Baby K was discharged from hospital with the bruising, his step-father telephoned the Health Visitor to report that the baby had a bruise near his eye which he said had been caused by an accidental clash of his head with the baby's. The Health Visitor asked him to bring Baby K to the GP straightaway and the GP, on seeing the bruise, referred the baby to the paediatrician.

63. A telephone conversation took place between the referring GP and the receiving paediatrician and although Baby K's mother took the baby to the hospital herself, both doctors are confident that, had the baby not arrived, they would have been alert to this and taken action and there is no need for a written protocol. The GP and the Health Visitor discussed the need for a referral to Children's Social Care and decided the Health Visitor would do this.

64. On examination Baby K was found to have bruises on his arm and abdomen, a skull fracture, two rib fractures of differing ages (including the one present at Baby K's previous hospital admission) and a possible injury to his leg.

65. When there are concerns that a child may have been subjected to an inflicted injury, consideration must be given to how the child can be protected both in the short term and in the future. The Pan Dorset Multi-Agency Child Protection Procedures sets out the framework for intervention. Any actions taken must be legal, compliant with policy and demonstrate good practice.

Use of Police Powers of Protection

66. The first action in any case of suspected child abuse is to hold a Strategy Meeting, this is a multi–agency meeting including a representative from the Police, Children's Social Care and Health, the purpose of which is to decide what investigation is needed and who will do what to protect the baby. In this case, it was part way through the Strategy Meeting (which was held at the hospital) that the full extent of Baby K's injuries became known.

67. If a child is at risk of immediate harm Section 46 of the Children Act allows for a police officer to detain a child in a place of safety for a period of up to 72 hours. Many professionals refer to this as a police protection order (PPO) but it is not actually an order which would be made by a court, the decision to act is ratified by a senior police officer. In this case, the immediate risk was that Baby K would be removed from hospital, therefore the police used their powers of protection and issued the instruction to ward staff that this was not to be allowed. Ms J and Mr L were arrested and taken to a police station for questioning. They were later released on police bail.

68. The use of police powers in this situation was appropriate, police officers were present at the hospital when the injuries were diagnosed and the use of police powers enabled protective action to be taken promptly.

Child Protection – Next Steps

69. If a child is removed from their parents it is good practice to bring the case before the Family Court as soon as possible. This ensures the parents have an opportunity to hear the causes for concern, why removal of their child is considered necessary and to be able to make representations to the Court about what they want. Most importantly, when a case comes to court, a Guardian is appointed whose job it is to represent the child and advocate on their behalf.

70. With the police questioning Mr J and Mr L and the time limit for the police powers running out, Children's Social Care sought advice from their legal department about how best to ensure Baby K's safety. They were advised to ask Baby K's mother to agree to Baby K being accommodated by the Local Authority and to be placed with foster carers under Section 20 of the Children Act. This would enable the police to continue their investigation and for Children's Social Care to begin their assessment and prepare to go to court at a later date. If Ms J wouldn't agree to Baby K being accommodated, the authority were ready to go to court for an Emergency Protection Order.

Use of Section 20 of the Children Act

71. Accommodating a child with the agreement of the parents, using Section 20, has been the subject of judicial comment. Use of Section 20 has increased steadily since 2013, and a recent case involving a Section 20 arrangement ended with the judge commenting that "accommodation of a child under Section 20 deprives the child of the benefit of having a guardian to represent and safeguard his interest and deprives the Court of the ability to control the planning for the child"[8]

72. In November 2015, just as Baby K's case was moving toward its conclusion, Sir James Munby, President of the Family Division, issued guidance about the misuse of Section

[8] Re N (children) (Children) (Adoption: Jurisdiction) [2015] EWCA Civ 1112

20 calling it “not just a matter of bad practice” but insisted: “It is wrong; it is a denial of the fundamental rights of both the parent and the child; it will no longer be tolerated; and it must stop.”

73. As a result of the concerns about the use of Section 20, Munby set out new guidance about what “future good practice requires.” It states:

    - Where possible, the agreement of a parent to a section 20 arrangement should be properly recorded in writing and evidenced by the parent’s signature.
    - The written document should be clear and precise and drafted in simple and straight-forward language that a parent can readily understand.
    - The written document should spell out that the parent can “remove the child” from the local authority accommodation “at any time”.
    - The written document should not seek to impose any fetters of the parent’s right to withdraw consent.
    - Where the parent is not fluent in English, the written document should be translated into the parent’s own language and the parent should sign the foreign language text, adding, in the parent’s language, words to the effect that ‘I have read this document and I agree to its terms.’

74. In this case the use of Section 20 to accommodate Baby K did not cause delay. A Public Law Outline (PLO) letter advising Ms J to seek legal representation and outlining the causes of concern, was issued to her a week after her arrest and the case was brought before the court about a month after Baby K had been removed from his mother’s care.

75. There are differing views in Children’s Social Care about the appropriateness of the use of Section 20 in this case. All the practitioners would have been alarmed had Baby K been removed from local authority care and therefore some senior staff consider that using Section 20 was not appropriate and that as the police powers ran out of time, an application for an Emergency Protection Order should have been made. This remains debateable, however the legal advice was sound and there was no significant delay in getting to court.

76. Since the Munby guidance has been issued, Dorset have been pro-active in seeking to understand it’s importance, training staff in the correct application of the law and monitoring its use. Anecdotal evidence indicates the use of Section 20 is decreasing.

77. The use of Emergency Protection Orders (EPO’s) is also monitored by Children’s Social Care but the Children’s Safeguarding Board do not routinely monitor the use of police powers to detain children in emergency situations.

For The DSCB

- In order to understand and monitor how children are being protected in emergency situations and to satisfy itself of how Section 20 of the Children Act is being used, the DCSB should consider monitoring the use of police powers of protection, the use of Section 20 powers and the subsequent journey of the child.

The Role of the Initial Child Protection Conference

78. When Baby K was removed from his mothers care, part of the advice given to Children's Social Care by their legal department was that a Child Protection Conference should be convened as soon as possible. The Child Protection Procedures state that a conference must be convened within 15 working days of the Strategy Discussion.

79. The procedures also say that if a child is already "looked after" they will not usually be the subject of Child Protection conferences, though they may still be the subject of Child Protection Enquiries.

80. A Team Manager is responsible for making the decision whether or not to convene a Child Protection Conference following completion of the Child Protection enquiries and the reasons for the decision must be recorded. Because this child was looked after, the manager decided not to call a conference.

81. It is helpful to remember that the purpose of a Child Protection Conference is not the same as a Looked After Child Review. A Child Protection Conference is an opportunity to bring together and analyse information about the child and his family in an inter-agency setting, to make judgements about the likelihood of the child suffering or continuing to suffer significant harm and to decide what action is necessary to safeguard the child and promote his welfare.

82. Whilst it might be exceptional to hold a Child Protection Conference for a child who is looked after, in this case after some discussion, the practitioners involved concluded it would have served a useful purpose. This case was reported to be unusual in that at the time of his injuries the child was relatively unknown to Children's Social Care, there was no allocated social worker and there had been no earlier opportunity for professionals to meet and share information. At day 15 after the Strategy Discussion, Baby K was still accommodated using Section 20 as the case had yet to come to court, plans were being put in place for his mother and step-father to have contact as evidence for the first court hearing was being collated.

Learning

- A Child Protection Conference can serve a useful purpose when a child is accommodated, especially if there has been little opportunity for professionals to come together and share information about the family.

For the DSCB

- The DSCB should satisfy itself that Initial Child Protection Conferences are being convened when necessary and that staff understand when it may be appropriate to hold a conference if a child is in the care of the Local Authority.

THE VIEWS OF BABY K'S FAMILY

83. Baby K's family were invited to contribute to this Review and Mr L and Mr L's mother discussed their experience with the Independent Reviewer, Ms J did not wish to participate. The Reviewer also had a conversation with Baby K's birth father; although he had not been involved in the care of the baby during the period of the review, he was able to contribute to an understanding of the family's story and of Baby K's experience.

84. Mr L expressed regret that Baby K had been injured and reflected on his and Ms J's lack of experience with babies and the challenges of parenting; in hindsight he feels the young couple were dismissive of advice about child care and child development which at the time he found frightening but which, on reflection, he now sees was helpful.

    He suggested Ms J's reluctance to engage with the services offered was based on fear and insecurity.

85. Reflecting on the initial bruising to Baby K, Mr L commented on how helpful and approachable the hospital staff were and how he and Ms J wanted to be seen as cooperating with the questioning about the bruises. He feels they were encouraged to come up with a suitable explanation.

LEARNING FROM THE FAMILY'S EXPERIENCE

86. Some health practitioners in this case described the difficulties of questioning parents/ carers about the possible cause of bruising to a baby and the tendency for them to reassure parents and seek an acceptable explanation, to be trusting and generally optimistic; for example by saying something like "I'm sure there's a reasonable explanation..." It is interesting to compare the reassuring approach with the NICE Guidance which asserts that all bruising in non-mobile babies should be regarded with suspicion.

87. As part of the Bruising Protocol there is a leaflet available for families which explains why a referral has to be made to a Paediatrician and Children's Social Care. The leaflet is particularly valued by health professionals because it explains that the action taken is procedural and not personal, that is not based on an assumption that a child has been intentionally harmed. The leaflet points out that bruising in "non independently mobile" children is rare and also that it is "occasionally caused by a deliberate injury;" it also sets out other possible explanations for bruising such as a blood disease or infection.

88. In his 2003 inquiry report into the death of Victoria Climbie, Lord Laming came up with the phrase "respectful uncertainty" suggesting social workers (and other professionals) should be more sceptical and mistrustful about what might really be happening behind closed doors. Learning from this case indicates that the initial challenge for professionals is how best to approach families when a baby is first seen with injuries, in a way which enables the family to be honest from the start about any difficulties they

may be experiencing with the baby's care and to admit if they have or might have caused an injury to the child.

89. Although this is a particularly difficult area of work within a system which involves the police, investigation and potential removal of a child, it is especially important because once an explanation for injuries has been agreed, it is very difficult for a parent or carer to change their view and also research shows, that for professionals, there is a tendency to persist in initial judgements or assessments and to re-frame, minimise or dismiss any contradictory new evidence.[9]

90. Additionally, acknowledgement from a parent/ carer that they have or might have injured the child themselves is a valuable first step in risk reduction and management.

Learning

- When bruising is first observed on a non-mobile child and a professional is seeking an explanation from the parents or carers, it is important to remember the NICE guidance and to approach the conversation in a way which enables the parents or cares to be honest if they have or might have injured the baby. Whilst engaging with parents is likely to promote more honest sharing, it is essential that the professionals continue to retain their focus on protecting the child.

[9]The oversight and review of cases in the light of changing circumstances and new information: how do people respond to new (and challenging) information? Sheryl Burton, National Children's Bureaux, 2009. Quoted in Baby Peter and the uncertainty principle, Mark Easton, BBC, 2009

SUMMARY OF LEARNING

Referrals, Process and Practice

- Whilst most referrals are accepted at face value, there will be times when professional judgement suggests a more probing response is indicated and further information sought before making a decision about appropriate action. For example, when the referral concerns a teenage parent who is new to the area.

- In this case that not all the information shared between the Health Visitor and Children's Social Care was recorded. If information sharing is to be effective in safeguarding children, it is important that information gathered over time by all agencies is recorded carefully and contributes to a picture being built up over time.

The Significance of Bruising in Non-Mobile Babies and Children

- There is a wealth of information about the significance of bruising in non mobile babies and its links to abusive care which needs to be reflected in guidance and protocols.

- When bruising is first observed on a non-mobile child and a professional is seeking an explanation from the parents or carers, it is important to remember the NICE guidance and to approach the conversation in a way which enables the parents or cares to be honest if they have or might have injured the baby. Whilst engaging with parents is likely to promote more honest sharing, it is essential that the professionals continue to retain their focus on protecting the child.

- Professional challenge is a vital part of the safeguarding system and all staff, however senior and experienced, should be open to challenge. All staff should also be confident to raise their concerns with colleagues and know how to escalate if they consider their views are not being heard.

- In order to obtain a full picture of family functioning and the impact of parental care on a baby, it is important to record social observations and discuss their relevance when assessing risk.

- The decision about whether it is safe to discharge a baby should always be based on the main carer of the baby, any reassurances which suggest a reduction in risk should be carefully considered.

Child Protection and the Legal Framework

- A Child Protection Conference can serve a useful purpose when a child is accommodated, especially if there has been little opportunity for professionals to come together and share information about the family.

FINDINGS FOR THE DSCB

- **Finding 1:** The DCSB should satisfy itself that the Bruising Protocol provides explicit, accessible guidance which is understood by all the professionals in the safeguarding system.

- **Finding 2:** In light of the findings of Serious Case Review S4, the DSCB will need to consider how to disseminate the learning from this SCR effectively in order that it reaches as many relevant child care practitioners as possible.

- **Finding 3:** The DSCB should satisfy itself that Initial Child Protection Conferences are being convened when necessary and that all staff understand when it may be appropriate to hold a conference if a child is in the care of the Local Authority.

- **Finding 4:** In order to understand and monitor how children are being protected in emergency situations and to satisfy itself of how Section 20 of the Children Act is being used, the DCSB should consider monitoring the use of police powers of protection, the use of Section 20 powers and the subsequent journey of the child.

APPENDIX

List of Agencies involved in the SCR

SCR Group
Designated Safeguarding Manager, Dorset County Council, Chair of SCR Group
Designated Nurse Consultant for Children, Dorset Clinical Commissioning Group
Lead Nurse Paediatrics, Dorset County Hospital NHS Foundation Trust (DCHFT)
DSCB Business Manager
Detective Chief Inspector Public Protection, Dorset Police

Agencies Participating in Review
GP
Action for Children
Dorset County Council Legal Services
Children's Social Care
Health Visiting
Paediatric Department, Dorset County Hospital
Police

GLOSSARY OF TERMS

Child Protection Procedures: These multi-agency procedures have been designed to assist agencies to work together to safeguard children. Every Local safeguarding Children Board publishes them. They are based on national guidance, Working Together to Safeguard Children.

Common Assessment Framework (CAF): Sometimes called the **CAF Pathway**, this is a process for gathering and recording information about a child for whom a practitioner has concerns identifying the needs of the child and how the needs can be met. It is a shared assessment and planning framework for use across all children's services and all local areas in the UK. Sometimes referred to as **Early Help**, it helps to identify in the early stages the child's additional needs and promote coordinated service provision to meet them

Finding of Fact Hearing: is a type of court hearing that considers evidence surrounding allegations of child abuse. It can be used in the family court to determine whether the alleged incidents happened and who might have been responsible. The Family Court is not a criminal court and cannot prosecute parents, findings are based the balance of probability and reported by a Family Court Judge. The findings can be used by other agencies to inform planning for children.

Intercostal recession- is when the muscles attached to your ribs pull sharply in, indicating that your airways are blocked.

Local Safeguarding Children Board (LSCB): These were established by the Children Act 2004 to enable organisations to come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. The purpose of this partnership working is to hold each other to account and to ensure safeguarding children remains high on the agenda across their region.
Or
Police Powers: Whenever a police officer has reasonable cause to believe that a child would be at risk of significant harm unless action is taken immediately s/he may:

- remove the child from the situation and take them to a place of safety
- take action to prevent the child's removal from a place of safety

When a police officer has taken such action the child is deemed to be in police protection. No legal order is necessary. The child may be in police protection for no longer than 72 hours.

Public Law Outline(PLO) : The PLO is a procedure for dealing with cases in the family Court. When Children's Social Care are considering Care Proceedings they will send a Pre-Proceedings letter, known as a PLO letter. The letter sets out the concerns and usually invites parents and their solicitor to a meeting to discuss the next steps.

SCR Review Group: this is the small group of senior managers delegated by the LSCB to set the terms of reference for the SCR and oversee the work of the independent reviewer including providing information local practices and context.

Section 20(1) Children Act 1989: places a duty on the local authority to provide accommodation for a child in circumstances which include:

- there being no person who has parental responsibility for him;
- his being lost or having been abandoned; or

  the person who has been caring for him being prevented (whether or not permanently, and for whatever reason) from providing him with suitable accommodation or care.

Or

- A local authority may provide accommodation for any child within their area

  even though a person who has parental responsibility for him is able to provide him with accommodation if they consider that to do so would safeguard or promote the child's welfare.

Any person who has parental responsibility for a child may at any time remove the child from the accommodation provided.

Section 47 Child Protection Enquiries: Section 47 of the Children Act 1989 places a duty on local authorities to investigate and make inquiries into the circumstances of children considered to be at risk of 'significant harm' and, where these inquiries indicate the need, to decide what to do.

Strategy Discussion: Children and Young People's Services must hold a Strategy Discussion/Meeting whenever there is reasonable cause to suspect that a child has suffered or is likely to suffer Significant Harm. The discussion should involve Children Services, Health and the Police; also the referring agency and other agencies involved with the family as appropriate Those participating should be sufficiently senior to be able to contribute to the discussions of the available information and to make decisions on behalf of their own agency.