Torbay Safeguarding Children Partnership

REPORT OF THE SAFEGUARDING CHILDREN PRACTICE REVIEW REGARDING

C101

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Contents

1. The incident that triggered the review.

1.1 C101's mother called 111 at 4am on the 4th of December 2022. She reported to have noticed that C101 had pain in her leg. C101 was seen in hospital at approximately 6am where it was suspected that she had an oblique midshaft fracture to her femur. A strategy discussion[1] was triggered and s.47[2] enquiries were commenced.

1.2 The outcome of the child protection medical investigations showed that C101 had suffered multiple fractures that occurred on more than one occasion. The fractures included a rib fracture and metaphyseal fractures[3]. The rib fracture was dated to have occurred "10 days" prior to the medical investigation[4]. The CT scan indicated that the skull fracture was an old fracture.

1.3 Both parents were arrested.

2. The purpose of this review.

2.1 This review commenced following the Rapid Review meeting held in December 2022. The recommendation from the Rapid Review Meeting was that there was such a detailed and thorough review of the information in that meeting, that there was no need for a Local Child Safeguarding Practice Review. The Torbay Safeguarding Children Partnership's Executive Group recognised that the Rapid Review meeting was comprehensive, however it was recommended that a Local Child Safeguarding Practice Review (LCSPR) should be undertaken. The National Panel later concurred with this view.

2.2 The Torbay Safeguarding Children Partnership was keen to elicit the learning from the review as soon as possible and requested an interim report from the author, so that any emergent learning could be acted on in a timely manner. This was completed on the 6th June 2023.

2.3 Findings of the Rapid Review meeting in December 2022 shaped the terms of reference for this review.

2.4 The full terms of reference for this review can be found in Appendix 1. These also set out the methodology and those engaged in the review process.

2.5 This review focusses on the period 22nd February 2022 to the 12th December 2022. The reason this scope period was to ensure that learning from the pre-birth period for C101 was taken into account and also to capture any learning from the investigation process after the injuries to C101 were detected.

[1] A strategy meeting takes place between a social worker and other agencies when they are worried a child may have suffered significant harm.

[2] A Section 47 Enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of the child.

[3] These fractures are associated with episodes of shaking a baby.

[4] Expert report 2022

3. Key themes arising from this review include:

Recognition and response to domestic abuse
Communication and information sharing
The importance of good quality, SMART, multi-agency planning
The importance of professional curiosity when working with parents/carers accessing substance misuse services
Assessing the strengths and potential risks from male carers

4. Family Composition.

	Role in the family	**Age (at the time of the incident)**
C101	Child who was harmed	8 weeks
C101's sibling	Sibling to C101	3 years

5. Family Background.

5.1 C101 and her sibling are full siblings. They had no contact with the maternal relatives and the only support available to the family was from the paternal grandparents.

5.2 A referral was made to early help in January 2021 by the GP. The family declined support at this time. The family came to the attention of children's services between October 2021 and March 2022. C101 was not born at this point. Concerns that prompted support for C101's older sibling included:

- Father's alcohol and cannabis use
- The mother feeling overwhelmed by the stressors on the family
- Feeling unsupported by the father in the care of C101's sibling
- The mother finding it difficult to prioritise C101's siblings needs
- The mother was pregnant with C101

5.3 This period of support ended after the father was believed to have successfully engaged with drug and alcohol services, a family group conference had taken place and it was believed that a clear contingency plan was in place if the family's circumstances changed.

5.4 Later C101 and her sibling were open to children's services as children in need from June 2022 to the date of the incident triggering this review. This assessment was started after the mother called the police, having realised that the father had been driving whilst under the influence of alcohol or drugs. She was concerned that he had relapsed from his drug and alcohol abstinence. He had left the family home by the time the police had arrived.

5.5 The mother described to the attending police officer her fears about the father's relapse and that she felt unsupported. She shared concerns regarding the couple's relationship[5], believing that the father had been unfaithful and he had accused her of having an 'affair' with her brother. This prevented any contact with her brother and wider family. She also told the police that she had been assaulted in November 2021 by the father, later describing this as being "restrained" when she was having a miscarriage. He 'restrained' her while she was hitting her stomach.

[5] Cited from Rapid Review Meeting Notes

5.6 C101's sibling was not present during this incident. This event led to a single assessment and a Child in Need plan for C101's sibling. Police carried out a DASH[6] risk assessment. This period of Child in Need planning lasted until December 2022, when steps were taken to secure the immediate safety of the children.

5.7 The father has a diagnosis of ADHD and reported to have used Ritalin and self-medicated with LSD in the past. Historically he had also used cocaine and magic mushrooms. The mother had pre-existing mental health issues including an eating disorder in her childhood and poor mental health, including post-natal depression after the birth of C101's older sibling.

6. A pen picture of C101.

6.1 C101 was born at 37 weeks. She was a small child, very petite but was described by the health visitor as being 'in proportion'. She had received her first set of immunisations and was not on any medication. When seen in November 2022 she was described by her mother as a 'settled baby' and that she was 'chilled'. Her weight was going up after some early feeding issues. These comments and observations were made a few weeks before the injuries were discovered.

6.2 Now that she is in a safe place she is thriving and developing the expected skills for a child her age. She has been described as a 'happy' baby, as 'content' and 'full of smiles'. She is almost rolling over and sitting with aid. She is smiling and 'babbling'[7]. Despite her fractures she was able to move freely with no evidence of pain or distress in January 2023.

6.3 C101's sister is also safe and thriving.

7. Views of the parents and wider family.

7.1 Unfortunately, the parents and paternal grandparents were not able to contribute to this review due to the ongoing criminal proceedings and the Finding of Fact hearing in July 2023.

8. Changes made since the commencement of this review.

8.1 Children's Services have implemented specific SMART planning guidance and training to improve the quality of Child in Need planning. A Child in Need Independent Reviewing Officer post has been introduced within the Local Authority's Safeguarding and Reviewing Service. The purpose of this role is to ensure consistency and quality in respect of Child in Need planning. This role has also been created to provide training and workforce development for front line practitioners on effective Child in Need planning.

8.2 Children's Services have produced Child in Need practice standards which set out expectations of social workers in respect of Child in Need planning and reviews.

9. Analysis and linked recommendations.

9.1 Identified good practice.

9.2 The hospital midwife recorded her observations of the father's handling of C101 and her concerns about the hygiene of the cup that the mother was using to feed C101. Her recording was of a high standard and is an example of good practice.

[6] DASH risks assessment measures potential risk to survivors of Domestic Abuse.

[7] At age 6 months

9.3 The family's GP was thorough in reviewing the paediatric liaison form received after C101's birth. This highlighted the concern about hygiene and the potential impact on feeding of C101, which the GP then asked the health visitor to follow up.

9.4 The frontline practitioners, managers and leaders that participated in this review were open and reflective and showed that they were keen to implement learning at the earliest opportunity. It is noteworthy that work to address any systemic, procedural or practice issues identified following C101's injuries, began from the point of the rapid review process meeting in December 2022.

9.5 Recognition and response to domestic abuse and controlling and coercive control.

9.6 The police responded to the mother's call in June 2022 when she discovered that the father returned home from work, having driven under the influence. When the police attended the family home the mother told the police that she had previously been assaulted by the father, later stating that she was "restrained" by the father when she experienced a miscarriage in November 2021. A DASH risk assessment was undertaken by the police. The outcome of the DASH risk assessment was deemed to be 'low' but the ViST[8] cited the risk as 'medium'. The DASH risk assessments were not shared in the report that was sent to the MASH.

9.7 Midwifery and health visiting staff did ask the mother if she was experiencing domestic abuse or felt 'safe' at home in the antenatal appointments leading up to August 2022 and a further four times leading up to October 2022. She did not disclose any domestic abuse. Midwifery staff do not have access to GP notes and therefore it would not have been possible to detect the indicators of domestic abuse in the GP notes in 2021 and 2022[9].

9.8 The GP was alerted to the fact that the father was 'controlling' in the report received from the MASH in June 2022. There was also a historical record in the GP notes relating to C101's sibling, where it was reported that the mother was 'threatened' by her husband in January 2021.

9.9 The Children's Services recording relating to this incident in June 2022 shows some good analysis of the fact that the mother may be 'scared of the father leaving her' due to being 'wholly financially dependent' on the father and also noting that she was pregnant, which is a time that women are at an elevated level of risk and harm[10]. It describes how she had ceased any contact with her brother due to the father's concerns about her relationship with him and how the mother's wider family lived some distance away. The language surrounding the description of the reported assault changed from 'assault' to the father 'restraining her' after she hit her 'tummy' at the time of the miscarriage.

9.10 The single assessment in respect of unborn C101 and her sibling did engage the father and was thorough in respect of the children's wider needs, seeing the children at home, analysing the impact of the father's working hours and his availability to co-parent as well as mother's need for support. However, there was no explicit reference to indicators of domestic abuse.

9.11 The indicators of domestic abuse were in the professional network but they were not pulled together in the children's services single assessment. This resulted in key information not being analysed and domestic abuse not being clearly articulated in the assessment. There was a recommendation that a DASH risk assessment should be completed by the social worker. However, this was linked to the rationale that the father 'repeatedly threatens to leave' the

[8] Vulnerability identification screening tool completed by the police

[9] See Fig 1

[10] Chisholm et al 2017; Devries et al 2010 cited from Supporting women and babies after domestic abuse. A toolkit for domestic abuse specialists. 2019. Women's Aid

mother. It is not clear if this was ever undertaken and the concerns about domestic abuse appear to be lost from the point of the single assessment.

9.12 A review of the chronology shows that there were indicators of domestic abuse, these are set out in chronological order below in Fig 1:

Fig 1:

Jan 2021	Note in the GP records that the father had threatened the mother
27.06.2022	MASH referral. Mother told police of being assaulted in November 2021 – later described as being 'restrained' by the father. DASH risk assessment completed but not shared across the multi-agency team around the child.
27.06.2023	A notification was sent to midwifery following the mother's call to the police from the MASH stating "while pregnant last time she hit her tummy and her partner had to stop her by restraining her"
27.06.2022	GP note stating that father was 'controlling'
July 2022	Single assessment commenced – mother 'scared of the father leaving her' due to being 'wholly financially dependent' on the father and also noting that she was pregnant. Describes how mother is isolated from her family. DASH risk assessment recommended but not undertaken.
17.08.2022	Assessment by peri-mental health services – mother described that father had secretly set up cameras to film her, due to concerns he had about her relationship with her brother.
24.08.2022	Entry by health visitor from Unborn Tracker meeting citing "partner reported to be gaslighting the mother by saying she is not sane"

9.13 The Domestic Abuse Act 2021 defines domestic abuse as abusive if it consists of the following:

(a) physical or sexual abuse

(b) violent or threatening behaviour

(c) controlling or coercive behaviour

(d) economic abuse

(e) psychological, emotional or other abuse

It does not matter whether the behaviour consists of a single incident or a course of conduct[11].

9.14 The Act goes on to describe coercive control, some elements of which appear to have been experienced by the mother; including isolation from her family, 'control', 'gaslighting' and stalking behaviours[12] i.e. being covertly filmed by cameras put in place by the father.

9.15 Unfortunately, these pieces of information were not recognised and analysed in the single assessment and the absence of any multi-agency planning meetings prevented any multi-agency professional curiosity, or challenge about domestic abuse or coercive control.

9.16 One practitioner reflected:

[11] Domestic Abuse Act 2021, S1 (3) p

[12] Domestic Abuse Act 2021 – descriptor of stalking behaviours. Para 58. P 34

"There is a difference between domestic violence and domestic abuse – we need to do more work on recognising coercive and controlling behaviour."

9.17 This comment was made after, with the benefit of hindsight, it was recognised that indicators of domestic abuse were present. She reflected that, there was no evidence of actual violence and the less obvious indicators were not recognised.

Linked recommendation 1:
For the Partnership to gain assurance that local single and multi-agency training offers in relation to domestic abuse promote the recognition of abuse, coercive and controlling behaviour and stalking behaviours and promote the consistent use of risk assessment tools such as the DASH.

9.18 Effectiveness of communication and information sharing

9.19 There was evidence of systemic failures in communication and information sharing from the referral in June 2022.

9.20 **Police**: The domestic abuse indicators that the mother shared when speaking to the police were not fully shared with the wider network of professionals as set out above.

9.21 **Midwifery:** The hospital midwife recorded her concerns about the father's handling of C101 and the hygiene concerns. An attempt was made to contact the allocated social worker, after a message was left on the social worker's mobile telephone no further contact was made.

9.22 There was no verbal handover from the hospital midwife to the community midwife, as the named community midwife had had time off sick. On the day of the Family Group Conference the named community midwife's case load was being covered by another midwife, who was new to the team. She did not see the concerns noted by the hospital midwife on the recording system. Practitioners have reflected that the current recording system flags up 'reminders' to highlight certain information. The 'reminder' function is so commonly used that practitioners can find themselves clicking through these to clear the screen so that they can access the system. The fact that the 3rd midwife was very new to the team and the information recording system, meant that she did not see the notes from the hospital midwife.

9.23 The newly allocated community midwife attended the virtual Family Group Conference and recorded the expectations of her as set out in the agreed family plan. These actions did not reference the concerns about the father's handling or the historical indicators of domestic abuse. The plan only required the midwife to see C101 every day, observe handling and record any positives or concerns, which is what would normally be expected of the midwife in the first days of C101's life.

9.24 **Health visiting:** There were 3 health visitors. The number of changes occurred due an administrative error. It was agreed that C101 was to become a Child in Need at the Unborn Tracker meeting[13] held in August 2022. There is an expectation that children in need are served by the 'universal plus' health visiting service, rather than the 'universal' service, which provides for children that don't have identified additional needs.

9.25 Despite the plan for C101 to be a Child in Need, she was allocated a health visitor from the 'universal' service who undertook the pre-birth visit. A different health visitor undertook the new birth visit. This error was then recognised and responsibility for C101 moved from the 'universal' service to the 'universal plus' service in late November 2022. This health visitor saw C101 twice before she was injured and admitted to hospital. The allocation of three health visitors in 3 months meant that neither of the health visitors got to know C101 and her family.

[13] a children's social care Panel which provides oversight and monitoring of pre-birth planning

9.26 The health visitor that was working with C101 just prior to her injuries was an experienced practitioner but had not received a hand over from the previous health visitor or given a copy of the initial birth assessment. The letter from the midwife setting out her concerning observations was addressed to the previous health visitor, resulting in the second and third health visitors not being made aware of the concerns.

9.27 The third health visitor attended the Child in Need meeting held on the 1st of December 2022. Prior to this meeting she was not aware of the outcome of the Child in Need assessment or what the Child in Need plan entailed.

9.28 **Children's social care:** C101 had four social workers. It is not unusual for children to experience one change of social worker when moving from an initial assessment team to a team with social workers that work with families longer term.

9.29 C101's second social worker had time off sick so C101 was allocated to a third social worker and finally allocated to a fourth social worker number in November 2022, who remains allocated to C101 to date. The changes in social worker were significant not only in terms of providing the family with the opportunity to develop relationships with those working with them but also impaired communication within and between agencies. The third health visitor allocated to the family in November attempted to make contact with the third social worker, but the responsibility for the case had moved to the fourth social worker. One contact took place between the health visitor and social worker until the Child in Need review meeting in December 2022.

9.30 The changes in social worker resulted in the original 'written agreement' which aimed to prevent the father from having unsupervised care of C101, not being handed on to the subsequent social workers. Although, having reviewed the evidence to date there was insufficient evidence to warrant precluding the father from caring for his children. The exclusion of a parent caring for their child is only usually for instances of extremely high risk.

9.31 The concerns about domestic abuse were identified in the single assessment but only in as much as the relationship appeared to be 'unstable'. As a result, the concerns about the father's handling of C101 and the indicators of domestic abuse were not relayed to the fourth social worker, resulting in her view that the family were 'low risk'.

9.32 In summary, C101 and her family experienced multiple changes of workers in the first eight weeks of C101's life which prevented effective communication and information sharing. These changes included:

- Three midwives
- Three health visitors
- Four social workers

Linked recommendation 2:
For the Partnership to seek assurance from all agencies that changes of worker are kept to an absolute minimum in the child's journey through the services.

Linked recommendation 3:
For health partners to consider:

- enabling a safeguarding alert on the information recording systems *that require an acknowledgement* before the practitioner can move on to other parts of the recording system, to ensure when concerns are noted these are read and acknowledged.

- Ensure health visitors fully explore records on the family history when a child is allocated.
- Ensure verbal handovers take place and when there are changes of worker a joint visit takes place with the previous and newly allocated worker.
- For local health partners to ensure that there are effective mechanisms to ensure that indicators of domestic abuse held in GP notes are communicated to midwifery and health visiting staff.

9.33 Opportunities for planning:

9.34 The Unborn tracker meetings in August and September 2022 recommended that a discharge planning meeting took place.

9.35 The pre-birth planning meeting was replaced by a Family Group Conference (FGC), which is not in line with procedures. The FGC was requested at very short notice leading up to C101's birth. This gave the, very able, part time FGC coordinator very little time to set the meeting up, prepare with the social worker or meet and prepare the family members. As a result, the safety plan arising from the FGC was not robust and only provided a plan for immediately after the birth of C101. The key worker from the Peri-Natal Mental Health Team was not invited to the FGC.

9.36 This was a missed opportunity to create a multi-agency support plan to meet the needs of the mother and children, as well as the opportunity to discuss:

- the concerns about hygiene
- the indicators of domestic abuse

9.37 It has not been possible to establish why the discharge planning meeting led by Children's Services did not take place and was replaced at the last minute by a FGC, as the worker that made these plans is no longer working for the authority. Discharge meetings usually happen shortly after discharge from hospital. This was a missed opportunity for the hygiene concerns, the indicators of domestic abuse and the concerns about the handling to have been pieced together.

9.38 The FGC coordinators that contributed to this review reflected that practice has changed since September 2022. Historically, when first set up, the team would have been flexible enough to offer conferences at short notice. Such a referral would not be accepted by the team in the current day, due to the tripling of numbers of referrals into the team and the role of the team being better established. Therefore, there is no linked recommendation in relation to family group conferencing.

9.39 The Child in Need plan created by the third social worker in September 2022 was completed with the following:

- C101's sibling's nursery
- A representative of the substance misuse service
- The parents

9.40 The Child in Need plan did not highlight the concerns about the father's handling or indicators of domestic abuse. It was not SMART[14] and only contained actions for the parents. There was no evidence of any support to be provided to the family. This plan was not shared with the health visitor or perinatal worker who was supporting the mother. It is expected practice that any plan arising from the FGC is included in any Child in Need planning. The FGC plan only focussed on the immediate needs of the family post discharge and did not address the ongoing support needs of the family. The Child in Need plan handed to the fourth social worker was not fit for practice. The Child in Need plan was completed approximately 10 weeks after the trigger referral in June 2022. This is not in line with good practice, given that the assessment appears to be regarding simple issues of parental substance misuse and 'support' for the mother.

9.41 There was a significant delay in holding the review Child in Need meeting which was, in part, due to a delay in allocating a social worker from the longer-term team, the fourth social worker.

9.42 The review meeting in December 2022 was attended by the C101's siblings' nursery and the third health visitor. Included was a verbal update from the substance misuse team. The Peri-Natal Mental Health Team were not invited to the review meeting.

9.43 By this time, the team around the family had changed. The only constant for the family was the nursery worker who had not met C101. The health visitor and social worker were newly allocated to the family.

Linked recommendation 4:
For Children's Services to provide assurance to the Partnership that the planned improvements and the introduction of a Child in Need Reviewing Officer impacts on the following:

- The quality of Child in Need (CIN) plans
- The timeliness of reviews of CIN plans
- The invitation of all partners to planning and review
- Records of CIN plans and reviews are shared with all of the team working with the children, including GPs

9.44 Effectiveness of the arresting procedures and safety planning post injuries

9.45 The terms of reference for this review required an examination of the use of arresting procedures immediately following the first injury to C101. The day that the injuries were detected a strategy discussion was held. At this time only the fracture to the femur had been detected and a decision was made to arrest the father and treat the mother as a witness. This decision was based on the following information:

- The father had cared for C101 between 8pm and 2am on the day the first injury was discovered by the mother.
- The mother shared a text message with a doctor that had been sent by the father, stating that he might have caused the leg injury by holding C101 over his head.
- The medical professional at the time felt this was a plausible explanation for the injury.

9.46 It was only on the 6th of December, following the outcome of the child protection medical investigations that the injuries that C101 had suffered were fully understood. It became apparent that C101 had a range of injuries, that could have occurred on more than one occasion.

[14] Specific, measurable, achievable, relevant and timebound

This triggered a second strategy meeting, following which both parents were treated as potential suspects and were arrested.

9.47 C101 was safe in the hospital and her sibling was placed in the care of the paternal grandparents. Both the police response and the multi-agency immediate safety planning appear to have been appropriate and responsive as new information came to light about the injuries. Therefore, there is no linked recommendation in relation to the application of the arresting procedures or the safety planning for the children.

9.48 Impact of Covid 19

9.49 The terms of reference specifically required reflection on any potential impact of the Covid 19 pandemic. There was no evidence from written records or feedback from practitioners that indicated that Covid 19 had a negative impact on services offered to this family.

9.50 Supporting parents with substance misuse issues

9.51 The father sought support from Walnut Lodge in February 2021 and later this was an expectation set out in the Child in Need plan in September 2022. He self- reported low levels of substance use, describing smoking 'two spliffs a day' and 'one can of beer a day'. He told the worker that he wanted help with abstinence but had not smoked any herbal cannabis or drunk alcohol for 12 days prior to the assessment. He was later discharged from the service after reporting that he had managed to remain drug and alcohol free.

9.52 There appears to be a lack of professional curiosity at the time of the initial assessment by the substance misuse worker about the amount that the father reported to be using. It was never questioned why the threshold for a Child in Need plan linked to his substance misuse was in place or why he was not 'allowed any unsupervised contact' with his child, when he was self-reporting low levels of usage and later abstinence.

Linked recommendation 5:
For Walnut Lodge and linked providers of substance misuse services to be made aware of the learning from this case review regarding professional curiosity when working with parents whose children are open to Children's Services.

9.53 Supporting fathers/male carers as parents

9.54 The father appears to have had very limited input into the single assessment in September 2022. The assessment sets out expectations from the social worker that he should prioritise his family's needs over that of his employers. However, there was a lack of clarity about the role of the father in caring for the two children and no assessment of the support that he may require. The second community midwife that was allocated to the family did meet the father and encouraged him to support the mother. She found him to be hard to engage at times and reluctant to be involved in parenting.

9.55 The first assessing social worker, did not know of the handling concerns raised by the hospital and this information was therefore not handed on to the following three social workers. The fourth social worker, and the current health visitor for the children had not observed the father's interaction with the children, leading up to December 2022 when the injuries to C101 were discovered. The combination of the multiple changes in worker and the father's working hours meant his parenting capacity was not assessed and it was assumed that the mother would be the main carer. There is no evidence that the father was asked if he wanted any support in developing his parenting skills.

9.56 There has been recent research carried out by the National Panel[15] which shows that:

> in the 'vast majority' of cases where babies have been injured or killed – men are the perpetrators'.
>
> (Opcit p6)

9.57 This research showed that contextual factors such as substance misuse, domestic abuse and living in poverty are linked to non-accidental injuries in children under the age of 1 year.

9.58 In this case the father's capacity to co-parent was not assessed and there was an unconscious bias leading professionals to accept that the mother would be the main carer and provide all of the care for the children. It is important that all services engage, support and intervene with male carers[16] to identify their role in the family and identify potential indicators of risk and/or support they might need.

Linked recommendation 6:
The Partnership to consider the introduction of a pre-birth tool to assist workers to identify the roles of each parent/carer in parenting and aid the identification of strengths and potential risk factors for newborn children.

Linked recommendation 7:
For the Partnership to be provided with assurance that the learning from the National Panel's research The Myth of Invisible Men. Safeguarding children under 1 year from non-accidental injury caused by male carers (2021) is disseminated across midwifery, health visiting, early help and social work services.

10. Conclusion

10.1 As with the majority of case reviews, the combination of the analysis of the history and the engagement of frontline practitioners has elicited some important learning. It is notable however that multi-agency safeguarding systems are complex and sadly, even if the indicators of risk were recognised by the multi-agency team, it is unlikely that this would have enabled practitioners to predict the harm suffered by C101.

[15] The Myth of Invisible Men. Safeguarding children under 1 from non-accidental injury caused by male carers. (2021)

[16] Opcit The Myth of Invisible Men. Safeguarding children under 1 from non-accidental injury caused by male carers. (2021)

11. Appendix 1

Local Safeguarding Child Practice Review
Terms of Reference
Child: C101

March 2023

1. **Reason and Context for Review**

1.1 This review relates to a young child who has been given the pseudonym C101. C101 has a three year old sibling. C101, her sibling and both of their parents were living together at the time of the incident in question. On 4th December 2022 C101 was presented in a very distressed state at Torbay Hospital ED by her mother, with C101 being suspected to have an oblique midshaft fracture to her femur. The mother gave no adequate explanation for the nature of the injury. C101 was eight weeks old at this time. Hospital staff alerted Children's Services to request a strategy meeting and the subsequent Child Protection medical revealed that C101 had multiple fractures which had occurred over more than one occasion, with it being deemed conceivable that some of the fractures had occurred ten days or more before hospital presentation. This information was formally communicated to the Local Authority on 6th December 2022, both parents were arrested by the police and the children became cared for under S20 within the same foster placement. The children were made subject to Interim Care Orders on 15th December 2022.

1.2 Further concerns regarding C101 and her sibling's welfare were identified within the Rapid Review process, with examples of these being:

- The parents being reported to have a poor relationship.
- C101's older sibling exhibiting concerning behaviour and development.
- The mother experiencing low mood.
- The mother being concerned about the father's level of alcohol consumption.
- The concerns above leading to the GP making a referral to Early Help services in January 2021 but the parents declined support.
- The mother made a referral in October 2021 reporting concern about the father's drug and alcohol use.
- The father was reported to have cared for C101's sibling whilst under the influence of substance/s.
- In June 2022 the mother reported to the police that the father was driving under the influence of alcohol, adding that his place of work is concerning in respect of illegal drug supply.
- The father reportedly had a sexual relationship with another person whilst the mother was pregnant with C101's sibling.
- The parental relationship dynamics and self-reports of transactional sexual behaviour which leads to a potential hypothesis of coercive control by the father.

- The father accused the mother of having a sexual relationship with her own brother whilst she was pregnant with C101.
- The father's rough handling of C101 in the hospital.
- Child in Need planning was in process at the time of the injuries to C101.

1.3 The Serious Incident notification was submitted to National Panel by the TSCP on 12th December 2022 and the Rapid Review meeting was held on 22nd December 2022, with the associated report being submitted to National Panel on 4th January 2023. Although the Rapid Review meeting concluded that all learning had been identified the TSCP Executive recommended the undertaking of a local CSPR, with National Panel responding to the TSCP on 8th February 2023 and concurring with this view. National Panel agreed with the lines of enquiry identified by the TSCP and Siobhan Burns was confirmed as the Independent Reviewer on 23rd February 2023.

2. Purpose

2.1 This review will be based on the key lines of enquiry recorded in section four below. However, during the review, if further learning opportunities are identified these will be added at the discretion of the TSCP C101 Review Panel. The key purpose of the review is to prevent future similar harm and learn lessons where appropriate to further safeguard and promote the welfare of children. The review should aim to identify systematic learning, rather than holding individuals or organisations to account for their actions.

2.2 If concerns are identified within the review process that fall outside these terms of reference, such as those of a safeguarding or misconduct nature, the Independent Reviewer will refer to the TSCP who will then consult with the relevant body to consider appropriate responses and processes.

3. Period under Review

3.1 The period under review is from the confirmed date of the mother's pregnancy, 22/02/2022, until 12/12/2022 when the SIN was submitted by the Local Authority.

3.2 The Independent Reviewer may also request summary background and contextual information outside of this period and analyse as relevant.

4. Key Lines of Enquiry

4.1 The following key lines of enquiry have been established, based on the findings of the Rapid Review, and have been noted by National Panel. Further questions have been agreed by the TSCP C101 Review Panel and are recorded under their linked line of enquiry via bullet points.

A	**Analyse the effectiveness of communication and information sharing between agencies during the period under review and identify if this led to missed opportunities to support/safeguard C101.**
B	**Report on the quality of CIN and safety planning for C101.** • Did the delay in care planning post completion of the single assessment on 6th September 2022 elevate risk and/or prevent the family accessing services? • Do local agencies understand the purpose and legal limitations of written agreements?
C	**Comment on the effectiveness of existing local systems to protect children. Are these robust enough and/or being applied correctly?**

	• Were effective child protection procedures initiated in line with WT2018 and correctly applied following the identification of C101's injuries? • Was safety planning initiated after the strategy discussion/s SMART, robust and effective, including the timely identification of the pool of potential perpetrators? • Review and comment on the timeliness of arresting procedures for both parents. • Review the impact on safeguarding of the lack of professional curiosity following the assumption that the father was the perpetrator following his statement that he dangled C101 by her legs.
D	**Comment on the accessibility and quality of professional supervision for staff engaged in the safeguarding of children.** • Were all professionals able to access supervision, and if not, why not? • How could local supervision be better used to improve the safeguarding of children?
E	**Review local agencies understanding of the importance of awareness and knowledge around feeding difficulties and associated impact on infants' safety.**
F	**Comment on whether agencies fully understood the status and impact of the parent's relationship.** • Did this impact on risk management? • Was there evidence of coercive control and domestic abuse, and if so, what were agencies responses?
G	**Review local multi-agency practice in respect of 'hidden fathers' and identify potential learning for local agencies.** • Was the father visible to services and considered within recording processes and care planning? • Review the pathway from midwifery services to health visiting to ensure it is effective and being applied correctly, including the frequency and level of health visiting for children subject to Child in Need or early help planning. • Identify risk and potential learning regarding the transition processes between midwifery and health visiting teams. • Do health practitioners routinely record the presence of birth marks or similar marks on a child's file? • Identify why Universal Plus health visiting status did not elevate the level of visits to the family in line with agreed local process. • Was whole family care planning considered by health practitioners?
H	**Review and comment on the residual impact of Covid 19 on local safeguarding and support services and determine if this impacted on C101's safety and care planning.**

5. Methodology:

5.1 This review will be carried out according to statutory guidance and using best practice to ensure appropriate learning opportunities are identified and analysed. The final report should identify recommendations that can be converted into SMART actions to assist learning. It is anticipated that the review will be conducted remotely, however if

'face to face' meetings are required the need for these will be evaluated in advance by the TSCP C101 Review Panel.

5.2 The Independent Reviewer will feedback progress to the TSCP at regular planned intervals via the TSCP C101 Review Panel. In situations where urgent/unplanned feedback is necessary this will be undertaken via the TSCP Business Team.

5.3 The TSCP C101 Review Panel will meet monthly, however meetings can be held more frequently if required at the discretion of the Chair.

5.4 The TSCP C101 Review Panel will consist of:

- Divisional Director, Safeguarding (Chair)
- Children's Social Care
- Police
- Designated Health Professional (covering the health system)
- Early Years (if required)
- Independent Reviewer
- TSCP Business Team
- Additional members as deemed necessary

5.5 Legal advice will be provided by the Local Authority Legal Department.

5.6 Communications/PR support will be provided by the Local Authority communication lead for Children's Services.

5.7 The TSCP Executive have requested an interim report be completed at the midway point of the CSPR timescale.

5.8 Final learning from the review will be presented by the Independent Reviewer in the form of a full CSPR report that will be completed to timescale as far as is practicable. The final draft report will be agreed by the TSCP C101 Review Panel before being presented formally to TSCP Executive Group for review and sign off via partnership business channels. Any agreed amendments to the report will be required to be undertaken by the Independent Reviewer.

5.9 The timescale for submitting the final version of the report to National Panel is six months from the TSCP being notified of the need to complete the local CSPR. The last submission date to National Panel is therefore considered to be 8th August 2023.

6. Review of Existing Materials and Papers

6.1 The Independent Reviewer will identify the information they require to undertake the review with the support of the TSCP C101 Review Panel. The information will be sourced and provided by the TSCP Business Team and partner agencies will be expected to comply with information requests (where legally permitted) in a timely manner.

7. Involvement of Practitioners and Staff

7.1 The Independent Reviewer will identify and engage with relevant practitioners, managers, and key workers to ensure any learning opportunities are fully incorporated into the reviewing process. It is anticipated that there will be at least one 'practitioner event', combined with the offer of 1:1 or small group sessions for workers to meet with the Independent Reviewer where this is deemed more conducive to the identification of learning. The TSCP Business Team will coordinate these events.

8. Involvement of Families/Other Parties

8.1 Parents, carers and family members of the siblings will be notified of the review by the TSCP and invited to participate at an appropriate time.

8.2 Involvement of other interested parties will be considered as appropriate by the TSCP C101 Review Panel.