1) Child L Background

L was born a healthy baby boy in March 2019, he resided solely with his mother. L's father was a frequent visitor to the home and he was reported to have been supportive. During the 8 weeks prior to the incident, L had one brief hospital admission to the paediatric assessment unit with a rash ('red marks' on his face) and excessive crying. He was referred for an Ultrasound when the health visitor noticed he had 'twitching legs'. L was seen by his own health visitor on two occasions and by a different health visitor for the 'birth home visit'. L was seen by the GP on 2 occasions during this time.

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2) L's father Background

L's father was well known to Children's Services, having been a child looked after for much of his childhood. He witnessed domestic abuse between his parents, who were prolific users of substances. L's father was identified as having anger and anxiety issues and he was referred to the Primary Care Mental Health Services 3 times between 2015-2018. Children's Services closed L's father's case in March 2017 because he no longer wanted any involvement. He was also well-known to police, his home having been subject to 3 drugs-related search warrants (in 2016, and twice in 2017), resulting in a conviction for drugs-related offences.

3) L's Mother Background

L's mother had no history with Children's Services or of offending behaviour. She engaged well with antenatal services, despite her having a number of different mid-wives involved with her antenatal care. There were 4 police contacts during her pregnancy. 2 of these contacts were in response to calls from her during (alleged) verbal arguments with L's father. There was also a complaint of threatening text messages to L's mother from his paternal grandmother. Within this 'malicious communication', the paternal grandmother also made reference to both L's mother and father being 'flat out on coke and weed'.

4) Circumstances that lead to the review

Emergency Services were called to L's family home on the 10th June 2019 and discovered that Child L was unresponsive. He was taken to hospital as a medical emergency. Tests revealed multiple bleeds to L's brain, two fractures to the skull and possible limb fractures. Both parents were arrested and were subsequently bailed. The Local Authority initiated care proceedings in respect of L. L's mother subsequently disclosed a more extensive history of domestic abuse than had previously been known to agencies. Both parents admitted to being substance users, namely cocaine and cannabis.

5) Time frame agreed

The timeframe agreed by the Panel for this Review was from 01/06/18 to 10/06/19. This included the period of L's mother's pregnancy and the first 10 weeks of his life. 10/06/19 was the date that L was taken to hospital by paramedics.

6) Practice and organisational learning

-Professionals should consider information from all available sources, even if it appears that the information may have a malicious intent.
-There was little attention paid to L's father's involvement in his parenting by both health professionals and Children's Services.
-Health professionals need to take every opportunity to make routine enquiries about domestic abuse.
-There were gaps in the midwifery service's documentation.
-The hand-over process between midwifery and health visiting was not comprehensive.
-L's mother did not have a named midwife and saw a number of different mid-wives for her ante-natal care.
-L's parents declined to view the video on 'shaken baby' syndrome.

7) Improving Systems and Practice

-Agencies should ensure that their staff are aware of the psychology of unconscious bias. In addition to stand-alone training, this should be included in training on assessment and Safeguarding. The concept of professional curiosity should also be included in all relevant training programmes.
-Information about fathers should be actively sought by health and social work professionals in all assessments of pregnant women and children's well-being. Professionals should make every effort to involve and engage fathers in assessments and should seek collateral information when risks are identified. ACEs and their potential impact on both parents and their parenting should be identified.
-CTMSB should ensure that its multi-agency pre-birth assessment guidance includes the above recommendation. Children's Services should review their guidance for undertaking proportionate assessments to ensure that information is gathered from a variety of sources and not from just one individual. When an assessment for a child is being undertaken, the parents' records should be checked in order to establish whether there is relevant information that might indicate a potential risk to the child that has not been disclosed.
-Midwives and health visitors should be updated about the Health Board's policy on 'routine enquiry'.
-The Health Board should review its record-keeping in the midwifery and health visiting service and ensure that recording by these professionals is of the required standard.
-The Health Board should ensure that the process for sharing PPNs with midwives and health visitors is robust.
-CTMUHB should review the process for the hand-over of cases from the community midwifery service to the health visiting service.
-CTMUHB should consider establishing a process by which pregnant women having consultant-led ante-natal care can still have continuity of care by a named midwife.
-There should be clarity as to whether it is UHB departmental policy still to offer the 'shaken baby' video (that was offered to L's parents to view in hospital and was declined). The UHB should ensure that all new parents are provided with information on this and that there is consistency across the Health Board area.