Child Safeguarding Practice Review in respect of	Baby D
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1. Introduction

1.1 This review focuses on the death of baby D, who was only 6 weeks old when he suddenly died. He was found unconscious and unresponsive by his father in the early hours of the morning. The father had taken him downstairs for a feed and could not recall if he had fallen asleep.

1.2 Sudden Unexpected Death in Childhood (SUDIC) protocols were commenced, and information was shared between agencies. At an early-stage unexplained bone regrowth was observed in the baby's legs. This necessitated further detailed expert investigation and reports.

1.3 Two weeks after the baby's death a preliminary post-mortem result was returned that indicated there were suspected injuries to the baby's ribs. The parents moved out of the UK jurisdiction due to family commitments and had intentions to work abroad. Both worked in roles which involved being in a position of trust in overseas countries.

1.4 The final expert views on the baby's injuries were awaited for a considerable time. Limited contact was maintained with the parents and in February 2020, it became known that the mother was pregnant. In June 2020, the expert reports were received and provided the view that there were no suspected deliberate injuries to the baby's legs but the fractures to his ribs were believed to have occurred 5-10 days before the baby's death and were unexplained. The investigation into the baby's death was designated by police as a criminal investigation with the parents then considered as suspects. It was established that the mother and father had moved to new roles abroad.

1.5 This review was commissioned to examine what information was known to agencies at the various stages and whether that information was appropriately shared to understand the nature of the injuries to the baby and to safeguard others.

2. The family

2.1 Both parents worked abroad in roles that would put them in positions of trust. The father has two other children who reside with their mother in another country. The family have not previously been supported or involved with any agencies apart from that provided to all families. The family move abroad and travel due to the nature of their work.

3. Background

3.1 The baby was born in August 2019 at 36+2 weeks gestation. Health records would indicate that pregnancy was relatively unremarkable in terms of concerns. The baby was born by caesarean section having presented as breech. Mother and baby were discharged home three days following the birth. There were no recorded concerns.

3.2 The day following discharge the community midwife completed a postnatal wellbeing visit. Mother and baby were seen to be well; the baby was breastfeeding on demand. There is clear documentation that safe sleeping was discussed and there was an appropriate care plan in place, which included advice, discharge information and contact numbers. The following day the second community midwife visit was also completed.

3.3 The next day the community midwife attempted what would have been the third visit but was unable to see the baby with the mother declining access. It is not apparent what the reasons were for this failed visit as the records are not clear. When discussed in the reflective workshop there were no concerns from this failed visit as further visits were subsequently achieved. The baby was seen 4 days later during the 14-day post birth visit and he was weighed and found to be above birth weight. A blood sample was taken due to prolonged jaundice in line with the Neonatal Jaundice Policy. The baby was discharged from community midwife care and suitable advice is recorded as being given. Between early September and October 2019, there were three contacts with the family by the breast-feeding support worker and a new birth visit from the health visitor. There were no concerns noted.

3.4 At the beginning of October, some three weeks after being discharged from midwifery care, the baby was taken to see the GP by both his mother and father. The parents stated that the baby was crying and distressed after food, that he was not winding well. This was said to be mostly occurring after midnight. The baby was examined and found to be alert and not dehydrated. It is recorded that given the weight gain it was unlikely that there was any serious cause. The parents were signposted to suitable advice.. Baby D was seen by an experienced GP. As baby at that time was only five weeks old they were yet to be registered with the practice and so the records were handwritten. The handwritten notes were not subsequently loaded onto EMIS[1]. This has since been addressed by the GP surgery. It is noted that babies are frequently not registered on a GP system until parents attend for the first time, usually at the 8 week postnatal check.

[1] EMIS – A digital clinical system supporting joined-up working across all care settings

3.5 In the early hours of the morning on the day following the GP appointment an ambulance was called to the family address on the report of a baby in cardiac arrest. The report taken at the time was that the mother had been upstairs asleep, the father had been downstairs on the sofa, with the baby on his chest. The father thought the baby felt 'floppy', he lifted him and realised he was not breathing. On the arrival of the ambulance the mother was undertaking CPR as she had been instructed during the call to emergency services.

3.6 The baby arrived at the hospital emergency department 16 minutes after the initial call. Despite resuscitation attempts, it was not possible to revive him, and it was determined that the baby had died. All resuscitation was in line with protocols and recorded appropriately.

3.7 A consultant paediatrician attended the emergency department and with police took the history from the parents. During the course of the history, it was established that the parents had consumed two bottles of prosecco the previous evening and the father also two cans of cider. The police did not feel the parents were intoxicated or were demonstrating the effects of alcohol.

3.8 Police attended the home address and the SUDIC protocols were commenced. A dedicated SUDIC nurse was in attendance at the hospital. Police attempted to contact the Children Social Care (CSC) Emergency Duty Team (EDT) but were unable to get a response until 8.40 a.m. The senior police officer dealing had contact with CSC and passed the information that was known at that stage, including the fact that the father had two children from a previous relationship who resided in another country, with their mother.

3.9 The CSC records show that the initial contact with police had indicated that the consultant paediatrician had examined the baby and his death had been by cardiac arrest, but it was not clear how this had been caused. The SUDIC Coordinator asked for confirmation of the requirement for an information sharing meeting as information had already been shared. Following discussion, the SUDIC Coordinator arranged for an information sharing meeting to take place later that day.

3.10 On the afternoon of the same day a SUDIC information sharing meeting took place, this meeting included the acute trust paediatrician, SUDIC coordinator and CSC manager. The police did not attend this meeting. The circumstances of the baby's death were discussed as they were known at this stage. This included the names and dates of birth of the father's children who lived abroad. The outcome of the meeting was that there were no concerns known at that stage. There would be a further meeting in two weeks. The post-mortem was being arranged, as was a skeletal survey. Police records at this stage show that there were no safeguarding concerns, that health services would lead on medical investigations into baby's death and that police would not be attending the skeletal survey.

3.11 Three days following the baby's death, police were informed by the Coroner that the skeletal survey had revealed possible fractures to the rear of the baby's leg and rib

cage, of which some appeared to be healing. This led to a suspicion of a non-accidental injury. There was telephone contact between the police and SUDIC coordinator but there was no referral or contact with CSC at this stage.

3.12 Over the following days it was established that there would now need to be a forensic post-mortem and a repeat of the skeletal survey by a paediatric radiologist, this was likely to take 3- 4 months to achieve a full expert opinion. The parents had moved to another country and were making enquiries regarding the progress of the post-mortem. At this time the police, SUDIC coordinator and Coroner were all in touch with the parents. The Community Paediatric Consultant with responsibility for child death review also became involved in this contact with the parents to explain the initial findings. It is apparent that there was a level of confusion regarding who would pass information to the parents. CSC were not updated with this new information at this time. There was no consideration regarding the parents now being in another country or where the father's other children resided or whether this required a referral to the Local Authority Designated Officer (LADO) on the basis that the parents worked with children.

3.13 One week (15th October 2019) after the potential injuries had been identified there was a child death review meeting. The purpose of the meeting was to review the circumstances of baby's death and ensure that appropriate mechanisms were in place to support the family and agencies. This meeting was part of the child death review process[1]. The meeting was attended by the Community Paediatric Consultant, SUDIC coordinator, CSC, health visitor, GP surgery safeguarding officer and police (joined part of the meeting by conference call). The post-mortem and CT scan carried out the same day were discussed. The post- mortem in addition to the suspected injuries to the baby's legs had revealed fractures to the side and rear of his ribs. There is no evidence of consideration of strategy meeting to address the potential risk to the father's other children or how this would be managed within the SUDIC process. Within the section of the discussion to address immediate safeguarding concerns there is no evidence that consideration was given by any representative at the meeting to the father's other children or to the parent's employment status and whether this required referral to the LADO.

3.14 The police investigation policy log for the same day recorded that the post-mortem had not revealed any conclusive explanation for the cause of the injuries. No cause of death had been established but non accidental injuries had been documented. Whilst there was an ongoing police investigation the investigative strategy at this stage was to continue to communicate with the parents in a supportive capacity as they were not designated as suspects. This was on the basis of inconclusive medical outcomes and that further medical opinion was required.

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[1] Chapter 5 Working Together 2018 - Child death review partners must make arrangements to review all deaths of children normally resident in the local area

3.15 Three days after the review meeting the SUDIC coordinator discussed with police the preliminary results of the post-mortem. It was agreed that the SUDIC coordinator would be the point of contact with the parents. The parents stated an intention to attend the UK for the funeral but stated they would be too emotional to be seen by any professionals. A request was made when the parents thought they may be able to be seen but no response was received.

3.16 There was no further update for around 2 months (mid-January 2020) when the SUDIC coordinator contacted the police for any update on the investigation. The response was that the parents had returned abroad, and the expert reports were still awaited.

3.17 At the end of February 2020, the police had email contact with the mother, she stated that she was now pregnant and wished to be left alone. There again was no consideration of any referral regarding this recent news to consider how this would be managed in the area where the parents now resided.

3.18 In mid-June 2020, a report was received from the paediatric radiologist which identified that there were no leg fractures. The fractures to the anterior ribs were likely to be caused by CPR, however the fractures to the posterior ribs were thought to have been caused 5 -10 days prior to the baby's death. In the absence of a plausible explanation, they were believed to be caused as a result of a non-accidental injury (NAI). As a result of this information the SUDIC coordinator made a referral to CSC.

3.19 The police made a policy decision that the case was now a criminal investigation and the parents would have to be interviewed under caution and treated as suspects.

3.20 The SUDIC coordinator shared the new information on the injuries with CSC. The records of the coordinator, CSC and police show that there was discussion which considered a strategy discussion, but this was not undertaken as the family were now resident in another jurisdiction.

3.21 Seven days after the receipt of the information on NAI a meeting was convened attended by police, CSC and the SUDIC coordinator. Other agencies were not notified of the meeting. The police updated the meeting with the fact that the parents were now abroad. The radiologist had stated that the rib fractures were not caused by CPR (the posterior were 5-10 days old) and the anterior caused just before death. It was a possibility that the baby's injuries were caused as a result of being overlayed. The fractures were not believed to be the cause of death and were unlikely to have impeded the baby's breathing.

3.22 At the end of June 2020, a referral was made by police to children services regarding the baby's unborn sibling. At the beginning of July 2020, CSC raised a number of queries regarding the action taken to date, including whether alerts had been put on the parent's passport and whether authorities had been informed in the country where the father's children resided and the country where the parents were now

located. CSC were proactive in making referrals to the Children Services where the father's children resided.

3.23 At the beginning of August 2020, a referral was made to the City of London LADO. The LADO was unable to progress the referral as the parents did not work for a London based organisation. The referral was made there as this is where the head office for the organisation for whom the parents worked was located.

3.24 In November 2020, authorities where the father's children resided made contact with the children and their mother, it was ascertained that there were no safeguarding concerns. This was over one year since the baby's death.

4. Analysis of involvement

4.1 It is acknowledged by this review and all guidance supporting professionals, that any child death is a tragedy, for the families and those involved[2]. This case presented particular challenges in the communication with parents, mainly due to the fact that the parents moved to another country very soon after the death and have remained there and in other jurisdictions since, apart from returning once briefly.

4.2 Professionals were left without face to face contact and relying on phone and email, this was difficult to achieve at a very difficult time for the family. The contact was necessary not only to keep the family updated but to also try to elicit more information from the family as the circumstances and medical examinations revealed more information over time. What clearly came through during the reflective discussion was that professionals tried really hard to communicate with the family sensitively in what were difficult circumstances.

4.3 The multi-agency protocols and procedures have been developed and refined over time to provide an agreed Joint Agency Response (JAR). The guidance relied on by professionals is both local and national. The policies referred to in this review are: -

- The Royal College of Pathologists, Sudden Unexpected deaths in Infants and Childhood, Multi Agency Guidelines for care and investigation, second edition 2016 (Chair Baroness Kennedy)
- West Mercia Multi Agency Protocol – Joint Agency Response – Sudden and Unexpected deaths in infants and children – March 2019
- HM Government – Child Death Review- Statutory and Operational Guidance (England) 2018 – sets out the Child Death Review Process as Working Together 2018 and is complimentary to the National SUDIC guidance above, where the processes overlap.
- Association of Chief Police Officers – Guide to investigating child deaths 2014 – currently being reviewed.

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[2] The Royal College of Pathologists, Sudden Unexpected deaths in Infancy and Childhood, Multi Agency Guidelines for care and investigation, second edition 2016 (Chair Baroness Kennedy)

4.4 Up to and immediately following the SUDIC meeting on 15th October 2019, what opportunities existed to recognise there were safeguarding concerns, and why did a referral not follow?

4.4.1 The West Mercia Multi Agency Protocol – Joint Agency Response – Sudden and Unexpected deaths in infants and children states that there should be an initial information and planning meeting within the first 48 hours of the death. This meeting will also consider the need for a strategy discussion. The protocol states that as a minimum it should include the police and health professional, with ideally Children Services involved. The guidance states that this meeting should take place before the family leave the hospital. It acknowledges that the meeting should be face to face but may need to be conducted by telephone. It was not possible to contact Children Services immediately and this did not happen until later on the morning of the baby's death. There was some discussion as to whether an information sharing meeting was required and following challenge from Children Services it was agreed that one would be convened that afternoon, which was then arranged by the SUDIC Coordinator.

4.4.2 The information sharing meeting on the afternoon of the baby's death was not attended by police, who were an agency in receipt of much of the information. This was a missed opportunity to exchange all known information and formulate a plan going forward.

4.4.3 The Hospital Trust records show that the result of the skeletal survey indicating a 'possible healing undisplaced fracture to the left femur' was not known at the time of the information sharing meeting and therefore could not be discussed at this stage.

4.4.4 Once this information was known it was confirmed that the post-mortem would be a forensic one and a further skeletal survey would be undertaken. Although there were injuries identified at this stage it was not conclusive that these were non accidental so for this reason it was considered that there were no known safeguarding concerns. Although there was discussion between police and the SUDIC co-ordinator Children Services were not notified and the updated information was not shared with them.

4.4.5 It was acknowledged that from the parents account they had consumed alcohol the previous evening. This was said to be sharing two bottles of prosecco and the father having two small ciders. When the parents were seen by police and health professionals, they were not displaying signs of being under the influence of alcohol. They were not asked to provide voluntary samples to indicate alcohol levels. This is subject to further comment in section 4.7.1.

4.4.6 In summary, from the meeting on 4th October to the meeting on 15th October 2019, it was considered that the circumstances known at that stage regarding the baby's death and the absence of any historical information regarding the family, supported a view that there were no safeguarding concerns at this time. For this reason, no

referrals were required. It was acknowledged that there was further information to be gathered and another meeting would be required.

Learning It is important that all appropriate agencies attend SUDIC information sharing meetings. The Joint Agency Response for SUDIC should ensure that the initial information sharing meeting is noted and that those notes are appropriately circulated. Where new information becomes available (including results of investigations such as skeletal survey results) that give rise to safeguarding concerns, such information should be shared with all appropriate agencies in a timely manner to ensure any other children or individuals are safeguarded. Where that information is received through the Coroner's Office then they should be informed when it is to be shared further for the purposes of safeguarding others.

Recommendation 1

Worcestershire Safeguarding Children Partnership should seek assurance that the Joint Agency Response to Sudden and Unexpected deaths in infants and children (in accordance with the West Mercia Multi Agency Protocol) includes:

i) All appropriate agencies are being invited to, attending and contributing to information sharing meetings.

ii) information sharing meetings are being minuted and notes appropriately circulated, and

iii) that when important information on medical examination becomes available it is shared with all appropriate agencies at the earliest opportunity.

4.5 When the information was shared on 15th October 2019 and the suspicion that these were non-accidental injuries in nature became known to the attendees at the SUDIC meeting, what were the blockers/challenges to a referral then being made?

At what point was there sufficient information available to professionals to trigger a referral to the appropriate LADO, and why was that referral not made?

4.5.1 The meeting of the 15th October, was the second information sharing meeting, the purpose of the meeting was to review the circumstances surrounding the baby's death, to discuss his life prior to his death and to ensure that appropriate support mechanisms are in place for both the family and professionals. The status of this meeting was discussed at the reflective event and within the Child Death Review process this was viewed as the Child Death Review Meeting (CDRM).

4.5.2 Bearing in mind at the time of the previous meeting on 4th October 2019, the skeletal survey had not been undertaken, the following information had been discovered between the two meetings.

- Potential injuries to left tibia and right femur (formation of new bone) and a skeletal survey would have to be repeated.
- Parents had moved to another country to be closer to the father's other children.

- Parents were dissatisfied with the findings of police and partners and wished all contact now to be conducted by email.

4.5.3 The meeting was chaired by the Community Paediatric Consultant, with the SUDIC coordinator, CSC, health visitor and GP practice safeguarding officer. The police joined part of the meeting by phone. The post-mortem was taking place at the same time as this meeting. The police updated the meeting that they had received a post-mortem report that day that the baby's tibia and femur would have to be subject of further specialist investigation. Also, that the baby's rib cage had fractures to the side and rear of the ribs, that would suggest they were not caused during CPR. These injuries would also require further specialist investigation. The police advised that there was still no known cause of death or an explanation of how the injuries were caused.

4.5.4 It was agreed at the reflective discussion, that at this point there was suspicion of non accidental injuries. Whilst the police investigation was seeking further clarification and the parents remained witnesses as opposed to suspects, there was information available to raise safeguarding concerns regarding the father's other children and to make a referral to the LADO.

4.5.5 The minutes of the meeting under the heading of 'immediate suspicious/child protection concerns' records that the parents use of alcohol on the night was discussed. Previously the parents had stated to the health visitor that they did not drink alcohol. There is no recorded discussion of what consideration should be given to the existence of potential non accidental injuries and the safeguarding implications that may present to the father's other children, particularly in the knowledge that any specialist view was likely to take several months. There was also no consideration of involvement of the Local Authority Designated Officer (LADO) due to the parent's potential involvement with children in other countries.

4.5.6 At this stage consideration could have been given to convening a strategy discussion. The West Mercia multi agency SUDIC guidance states '*If, at any stage, concerns are raised that abuse or neglect may have contributed to the infant's death, or any other significant concerns emerge about possible child protection issues, an initial multi-agency strategy discussion/meeting should be convened by children's social care.'*

4.5.7 In this case although there were safeguarding concerns on receipt of the new information and with the knowledge of potential contact of the parents with the father's other children, a strategy discussion would not have been appropriate as the parents were not in this country. Any discussion needed to take place where the parents and the father's children resided. What was important was that the information was appropriately shared with the country of residence and it was clear to all how and by whom this was to be undertaken. This could have been managed within the meeting of the 15th October 2019.

4.5.8 The consideration of risk to the father's children was added to in February 2020, when the police received information from the mother that she was pregnant. This did not prompt any referral or contact with other agencies at this stage. In June 2020, more information was received on the nature of the baby's injuries, which were sufficient for the police to classify the investigation as a criminal one and the parents as suspects. There was discussion between the police, SUDIC coordinator and CSC about the requirement for a meeting regarding the risk to the unborn child and this to include the Children Services for the area where the family now lived but this did not occur at this stage.

Learning There needs to be early consideration of the circumstances of the case to understand if abuse or neglect is suspected or whether significant concerns arise regarding potential child protection issues and how this is going to be managed, either by a strategy discussion or where that is not appropriate through the child death meetings. This consideration should include reference to the Worcestershire Levels of Need document[3]. What is important is that the concerns are recorded, and it is clear how and by whom any concerns are to be shared and addressed.

Recommendation 2

Worcestershire Safeguarding Children Partnership should seek assurance from the Child Death Overview Panel that:

Where abuse and/or neglect is suspected within a SUDIC Joint Agency Response, then a decision must be made and recorded, using the Levels of Need Guidance, as to whether there are specific risks for other children and therefore whether to convene a Strategy Meeting in respect of any siblings or other children in contact with, or cared for by the parents or carers.

4.6 What was the consideration given to the safety of the half siblings and the unborn child from the point this information was known?

4.6.1 The area of safety of the siblings living in another country has been covered in the previous section.

4.6.2 Police first became aware that the mother was expecting another child in February 2020, when the mother notified them by email and requested no further contact. At this time, the mother and father were in another country. There is no record at this time that this information was shared with other agencies or consideration was given to making a safeguarding referral. A referral was made at a later date, June 2020, after the injuries were confirmed as non-accidental. This was some 4 months after the receipt of the initial information. Taking into account the knowledge of suspected non accidental injuries to the baby and the ongoing investigation a referral should have been made at the earliest opportunity. It is acknowledged that the same

[3] Multi Agency Levels of Need: Guidance to help support children, young people and families in Worcestershire. 2021.

difficulties on contact with authorities in another jurisdiction would have been encountered but this should have been progressed earlier.

4.6.3 The West Midland Safeguarding Procedures covers safeguarding children from abroad who arrive in the UK, including specific guidance and signposting for children arriving from the same jurisdiction as was relevant in this case. The guidance does not extend the advice on making a referral on a UK child now abroad or who is unborn and whose parents are abroad. Consideration should be given to signposting professionals to other support[4] and including this in local guidance.

Learning Where the investigation is ongoing, if information is received which raises a new or additional safeguarding concern a clear decision should be made whether this will be managed within the SUDIC process or whether this requires referral or strategy discussion.

Recommendation 3

Worcestershire Safeguarding Children Partnership to seek assurance that the local and regional multi-agency procedures provide sufficient guidance on dealing with risks to children who have moved with their parents to another country.

4.7 What process/procedure/system changes and/or workforce development are required to prevent such a recurrence within the SUDIC process?

4.7.1 Where a SUDI occurs and the parents use of alcohol is a potential factor, the parents should be asked to provide a voluntary sample to assist with understanding the level of consumption. It is recognised that this is a difficult judgement at a sensitive time but if not achieved at the time it will leave unanswered questions at a later stage. This is outlined in the West Mercia Multi Agency Protocol – Joint Agency Response – Sudden and Unexpected deaths in infants and children – March 2019.

4.7.2 When the baby was seen by the GP the day prior to his death, the notes were not uploaded to EMIS due to the child not being registered on the system. This was addressed by the relevant GP surgery, but it would be timely for other GP's to be reminded that when it has been necessary to make handwritten notes, there is a necessity for those to then be uploaded once the EMIS record is available.

5. Conclusion

Following the baby's death, the SUDIC protocol was implemented with scene and hospital attendance undertaken appropriately. There were discussions regarding the convening of an initial information sharing meeting as information had been shared between police, health and CSC.

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[4] Child Protection from Children & Families Across Boarders (CFAB) - https://www.cfab.org.uk/

The meeting did take place on the afternoon of the day of the baby's death, but police were not present, this was a missed opportunity for all relevant partners to meet, exchange information and decide on next steps.

At the time of this meeting the information regarding potential non accidental injuries was not known.

Within a matter of days, the initial findings on non-accidental injuries was received, it was recognised that further exploration and expert opinion was required. A further multi agency meeting was convened as part of the Child Death Procedures (Working Together 2018). The emerging picture of potential non accidental injuries was discussed but there was no consideration or action discussed regarding the potential risk to the father's other children or regarding the parent's employment involving working with children. In this case the issues could have been managed in a robust SUDIC process.

In February 2020, the police received information that the mother was pregnant. This information was not shared at this time and no consideration was given to the risk to the unborn child.

In June 2020, information was received that the rib injuries to the baby were considered non-accidental and as a result the parents were deemed to be suspects for causing the injuries and required to be interviewed under caution on that basis. A meeting was convened, and CSC advised police that a referral should be made to the authorities where the parents now resided.

There is no doubt that these considerations were made more complex by the emerging information over a period of time, which impacted on the communication with the parents. This communication was further complicated by the parents moving to other jurisdictions and how any notifications would be managed.

6. Recommendations

Recommendation 1

Worcestershire Safeguarding Children Partnership should seek assurance that the Joint Agency Response to Sudden and Unexpected deaths in infants and children (in accordance with the West Mercia Multi Agency Protocol) includes:

iv) All appropriate agencies are being invited to, attending and contributing to information sharing meetings.

v) information sharing meetings are being minuted and notes appropriately circulated, and

vi) that when important information on medical examination becomes available it is shared with all appropriate agencies at the earliest opportunity.

Recommendation 2

Worcestershire Safeguarding Children Partnership should seek assurance from the Child Death Overview Panel that:

Where abuse and/or neglect is suspected within a SUDIC Joint Agency Response, then a decision must be made and recorded, using the Levels of Need Guidance, as to whether there are specific risks for other children and therefore whether to convene a Strategy Meeting in respect of any siblings or other children in contact with, or cared for by the parents or carers.

Recommendation 3

Worcestershire Safeguarding Children Partnership to seek assurance that the local and regional multi-agency procedures provide sufficient guidance on dealing with risks to children who have moved with their parents to another country.

Appendix A – Terms of Reference and Methodology

1.1 The time period covered by this review commences on 28th August 2019 (date of the baby's birth) to 26th June 2020.

1.2 This case was discussed by the Rapid Review panel in August 2020. The purpose of the review panel under Working Together 2018 is to: -

- Gather the facts about the case, as far as can be readily established.
- Discuss whether there is any immediate action needed to ensure children's safety and share any learning appropriately.
- Consider the potential for identifying improvements to safeguard and promote the welfare of children.
- Decide what steps to take next, including whether or not to undertake a national Child Safeguarding Practice Review or a Serious Case Review.

The panel decided that the case met the criteria for a Child Safeguarding Practice Review (CSPR), and the National Panel agreed with that decision.

1.3 The independent author was engaged in November 2020, and the terms of reference were agreed for the case (appendix A). The below agencies were identified as being involved in the case. Each provided information of their involvement which was developed into a chronology.

- Worcestershire Children Social Care
- West Mercia Police
- Worcester Acute Hospitals NHS Trust
- Herefordshire and Worcestershire Health and Care NHS Trust
- Wye Valley NHS Trust
- Herefordshire & Worcestershire CCG (on behalf of GP practices)
- West Midlands Ambulance Service
- Birmingham Children's Hospital (Radiology)

1.4 The following area key lines of enquiry were developed for the terms of reference and agencies providing information were asked to focus on these areas.

- Up to and immediately following the SUDIC meeting on 15th October 2019, what opportunities existed to recognise there were safeguarding concerns, and why did a referral not follow?
- When the information was shared on 15th October 2019 and the suspicion that these were non-accidental injuries in nature became known to the attendees at the SUDIC meeting, what were the blockers/challenges to a referral then being made?

- At what point was there sufficient information available to professionals to trigger a referral to the appropriate LADO, and why was that referral not made?
- What was the consideration given to the safety of the half siblings and the unborn child from the point this information was known?
- What process/procedure/system changes and/or workforce development are required to prevent such a recurrence within the SUDIC process?

1.5 All agencies were invited to a reflective learning workshop, due to the covid restrictions this was conducted virtually. The attendance and engagement in the workshop was good and reflected the concerning nature of this case. Practitioners were also asked to complete feedback worksheets prior to the workshop, during and after it. This allowed for all views to be collected despite the barriers that working virtually may present. The information and themes form the workshop and worksheets are reflected in the narrative of the report.

1.6 Interviews were conducted following the reflective workshop to expand on information on certain areas.

Appendix B – About the author

The author in this review is Jonathan Chapman, he has no prior involvement with the case and is not connected to any of the agencies involved. He is a retired senior police officer, who had responsibility for strategic and operational safeguarding and was a senior investigating officer. He has undertaken serious case reviews, safeguarding adult reviews, MAPPA case reviews and domestic homicide reviews, with various boards across the Country. He has also worked with Clinical Commissioning Groups, The Church of England and the third sector on safeguarding matters.