Merton
Safeguarding
Children Partnership

Baby Grace

Child Safeguarding Practice Review

August 2021

1 Executive Summary

1.1 Grace died in 2017, aged one month. Post-mortem forensic evidence showed that she had been shaken on three separate occasions and had 27 fractures. In November 2020, both her parents were found not guilty of murder, but both were convicted of causing or allowing the death of a child.

1.2 After the parents were charged with murder in Spring 2019 the Merton Safeguarding Children Partnership agreed to commission this review to learn lessons and to ascertain if any changes to local systems were required, as a result.

1.3 The review concentrated on the services provided during the pregnancy, the birth, and the month of Grace's life. Local services had limited contact with Grace and her parents, mainly providing universal services for ante-natal and immediate post-natal support and care. These contacts met expected agency standards. Midwifery, Health Visiting, and the GP Practice had no concerns about Grace's welfare. In the few contacts with professionals Grace's mother, although stressed at times, was assessed to be able to parent Grace well. There was no evidence that Grace was at risk of harm, or that there were any difficulties in the parents' relationship – this only became apparent, in hindsight, through the criminal investigation, after Grace's death.

1.4 A core hypothesis of the review was that the injuries to Grace may have been caused by a reaction to crying and parental stress. This led to consideration of how new parents are prepared for and supported in ante-natal and post-natal care, including the possible impact of crying. Supplementary questions were: How well are fathers supported in ante-natal and post-natal care? And: How confident are practitioners in raising questions about the possibility of domestic abuse?

1.5 Grace's parents were invited to contribute to the review but did not respond.

1.6 The main lessons were identified as:

- How agencies help (new) parents to manage possible stresses and triggers which may lead to shaking a baby
- How agencies involve fathers in ante-natal and post-natal assessments and care; and
- How agencies assess possible risk of domestic abuse through routine enquiry and other measures.

- Consideration was also given to the need to ensure continuity of care across Maternity, Health Visiting and GP Services in busy workloads.

1.7 The review has shown that at the time (2017) and in 2020 the local peri-natal services in Merton were working well to screen parents for possible risk and to provide support at a universal level. However, it was recognised that Midwifery Services and Health Visiting Services are very stretched and would need more time and more contacts with parents to establish effective support relationships where a parent may trust more and share any difficulties. When there is no apparent risk or reason to doubt parents, their statements must be accepted.

1.8 It has also shown that pressures on services can mean that transfer of support between Midwifery, Health Visiting and GP can be more remote and automatic as there may not be time for

conversations to pass on information. Wider consideration beyond this case showed that when concerns had been noted there was more probability of information being shared effectively across services.

1.9 There are recommendations for the Safeguarding Partnership and local agencies to review arrangements for:

- Provision of parenting education for new parents, including the impact of and responses to crying,
- The involvement of fathers in ante-natal and post-natal support services,
- How frontline practitioners are trained and supported to include screening for domestic abuse (routine enquiry) in their overall assessments,
- Continuity of support arrangements between Midwifery, Health Visiting and Primary Care in early post-natal provision, and
- Promoting knowledge of the Domestic Violence Disclosure Scheme (Clare's Law); including to frontline practitioners so that they can share it with service users.

2 Introduction and reason for the review

2.1 Baby Grace died in September 2017 following cardiac arrest caused by traumatic brain and spinal cord injury. She was one month old. She was in the care of her parents at the time of her collapse. The death was initially assessed as likely to have been non-accidental and caused by one or more episodes of shaking.

2.2 The Merton Safeguarding Children Board[1] was informed and considered whether the circumstances met the requirements for a Serious Case Review[2]. Additional information was awaited from post-mortem forensic analysis and the criminal investigation. Local systems errors meant that the MSCB was not informed of the outcome of the forensic and criminal investigations until April 2019 when the Board learned, indirectly, that Grace's parents had both been charged with her murder and causing or allowing the death of a child.

2.3 The Merton Safeguarding Children Partnership (MSCP) then commissioned a Local Child Safeguarding Practice Review (LCSPR) to learn from the services provided to Grace's family whether there were any key lessons and any improvements which may be required to single-agency or multi-agency child welfare or safeguarding arrangements.

2.4 The MSCP agreed the Terms of Reference[3] and appointed an Independent Case Review Panel and Independent Reviewer[4]. Information and analysis were gathered from the agencies which had had contact with the family. These were separate community and hospital-based midwifery services, primary health care, health visiting and local police.

[1] The Merton Safeguarding Children Board has been replaced by the Merton Safeguarding Children Partnership.
[2] Serious Case Reviews were then governed by statutory guidance in **Working Together to Safeguard Children, 2015**. SCRs have been replaced under **Working Together to Safeguard Children, 2018** and such reviews are now undertaken as **Child Safeguarding Practice Reviews,** since September 2019.
[3] Terms of reference – see Appendix (10.1)
[4] Review Panel details see Appendix (10.2)

2.5 The focus for the review was agreed as the period from pregnancy to Grace's death, namely, December 2016 to August 2017. Information became available after Grace's death about tensions and possible domestic abuse within the parental relationship. This was hindsight but the Review Panel considered the information with a view to analysing whether it could have been identified prior to her death and whether it was significant. The Review started in December 2019.

2.6 A decision was made in January 2020 that, as the trial was imminent (scheduled for March 2020), the parents' participation in the review would be delayed and actively sought after the trial. The trial was underway but was stopped by the national measures put in place because of Covid-19. The parents were then informed of the review and were invited to contribute their views on the services up to Grace's death. They did not respond to the invitation. The second trial concluded in November 2020.

2.7 A meeting was held with Practitioners in September 2020 to seek their views about the services provided, and the systemic context and wider provision of services beyond this case, this was to test whether lessons emerging from this review are applicable more widely.

3 Family background

3.1 Grace was said to be a very wanted child, her mother described her as a 'miracle baby'. She was born healthy, with no disabilities. She was the first baby to her mother but the third baby to her father. It is not known how much he was involved in the direct care of the first two children.

3.2 Grace's mother had separated from her husband. She started a relationship with Grace's father. The parents were said to be living together at the time of Grace's birth in a home owned by Grace's mother.

3.3 Grace's mother was economically self-sufficient, self-employed in a professional role. Grace's father was a self-employed workman.

3.4 The family was of White British (Mother) / European (Father) background.

4 Local Agencies' Involvement and Services Offered to Grace's Family December 2016 – August 2017

4.1 From mid-December 2016 the local hospital became involved. Grace's mother self-referred to Midwifery Services in December. She was seen twice in December for scans and completed a self-referral form giving her background.

4.2 In early January, Grace's mother was seen for a booking appointment with the Community Midwifery Team. She was noted to be unemployed (which was not the case, she was self-employed). Her relationship with Grace's father and his occupation were noted. He was said not to be resident in the home at that time. Grace's mother reported no history of mental illness, and no worrying social factors or involvement with any other relevant agencies. In this contact **Routine**

Enquiry[5] into the possibility of domestic abuse was not undertaken; the reason is not clear as it is not recorded if Grace's father was present. His presence might have been a reason for not asking about domestic abuse.

4.3 Grace's mother was seen again in January twice for routine blood tests and a further scan.

4.4 In February, she was seen by a Midwife and was asked whether there was any history or concerns about domestic abuse (routine enquiry). She said not.

4.5 A pre-birth notification was sent to the Health Visiting Service, as per routine protocol.

4.6 In February, March, April, and May Grace's mother attended Midwifery-led ante-natal care and her local GP Practice appropriately and no concerns were identified. In June, she was described by a Midwife as "ante-natally well".

4.7 In March 2017, the Police attended a complaint at a different address, in relation to Grace's father and another person, who was seeking assistance in getting him to leave the property. No harm was identified and no allegation of assault or of a crime was made, and no further investigation was required. There was no reason for the police to link Grace's father with Grace's mother from this incident. Police records would have shown that in 2009 he accepted a police caution for common assault of a previous partner (domestic abuse).

4.8 At the end of May, Grace's mother was seen at the GP Practice. She was 29 weeks pregnant. There were no concerns about the developing baby. She was provided with a medical certificate for time off because of stress at work, for six weeks.

4.9 In June, the Health Visiting service reviewed the information about the pregnancy and assessed that Health Visitor contact was not required pre-birth, as there were no identified vulnerabilities. From the information provided this was appropriate.

4.10 Grace's mother saw a practitioner at the GP surgery for an ante-natal examination when she was 32 weeks pregnant. There were no concerns. A social history was taken, noting that mother was now signed off until the birth because of stress at work. She reported feeling much less stress.

4.11 In early July, mother attended the hospital for a routine scan. There were no abnormalities or concerns. Later in the month, she attended the GP practice for a minor unrelated health matter.

[5] **Routine Enquiry:** Health professionals' responsibilities "Your role should be matched by the level of training you have as recommended in the NICE guideline on domestic violence and abuse and should enable you to undertake a universal response or more specialist response as follows: …Level 2: For doctors, nurses, public health nurses, midwives, social care professionals, substance misuse workers and youth workers – able to undertake **routine enquiry**, assess safety risk and offer a referral to specialist domestic violence services Specialist" "All health practitioners, whether working in emergency, acute, primary care or community health, have a professional responsibility, if you identify signs of domestic abuse or if things are not adding up, to ask patients alone and in private, whether old or young about their experience of domestic or other abuse, sensitively. Routine enquiry into domestic violence and abuse is Department of Health policy in maternity and adult mental health services"
https://www.gov.uk/government/publications/domestic-abuse-a-resource-for-health-professionals

4.12 Mother had two more ante-natal scans in July and was admitted to hospital at the beginning of August for planned induction of labour.

4.13 It would have been usual practice for parents to have been informed of ante-natal classes, to which fathers are also invited. There is no record that Grace's parents attended any ante-natal classes provided by the Midwifery Service. *Information gained after the trial, from the investigation, says that father reported having attended National Childbirth Trust (NCT) ante-natal classes.*[6] *It is not clear if mother also attended but it is assumed that this would usually be the case, unless father had attended previously in relation to an older child. This attendance does not appear to have been known to the local Midwifery Service at the time and would have been a voluntary and privately made arrangement.*

4.14 Father attended Grace's birth. Grace and her mother were discharged home two days later. Mother was given standard post-natal advice and parenting information[7] and the Personal Child Health Record[8] (the 'red book') for Grace – the personal record also contains parenting advice and information. The hospital notified the Health Visiting service and GP practice about the birth. This is routine practice.

4.15 Home visits were made by a Community Midwife the next day and on two more occasions. The final two contacts with a Midwife were at the Post-Natal Clinic. On each of the five post-birth Midwifery contacts mother and Grace were seen to be well. Father was at home for the first home visit but did not take an active part and was in a different part of the accommodation.

4.16 The Midwife was involved over a longer period than was usual in response to issues with Grace's birth weight. At one week she had dropped below birth weight. A feeding plan was discussed. Grace's mother had been worried about feeding and reported some disagreement with Grace's father over this. Two days later the weight was increasing.

4.17 At twelve days the Midwife noted small, continued weight gain, but that Grace's mother reported problems breastfeeding. A referral was made for Grace to have a tongue-tie corrected although it was assessed that this was not impeding feeding. (Grace's mother had previously declined a referral). Grace's mother was advised to attend a breastfeeding support group.

4.18 The Health Visitor undertook the routine New Birth Visit the same day but separately, when Grace was twelve days old. Grace was mainly breastfeeding, with some supplementary formula milk. She was due to have her tongue-tie released. The Health Visitor noted that Grace had a sticky eye. Mother reported that she was, herself, healthy and healing well. All areas of post-natal health promotion were discussed with mother, as per the Health Trust's New Birth Visit Protocol. Mother did not report any domestic violence or abuse in her relationship when the health visitor queried this using **routine enquiry.** She did not report any symptoms of post-natal depression. The Health Visitor asked about Grace's father and was given his details.

[6] NCT Ante-natal courses | Find a local ante-natal class | NCT

[7] This covered: Baby Blues, Birth Registration, Reducing Risk of Sudden Infant Death Syndrome, Contraception, Crying Babies, and post-natal maternal self-care.

[8] Personal Child Health Record - Personal Child Health Record (PCHR) | RCPCH

4.19 The Health Visitor had no concerns about Grace or her mother and assessed the family as requiring only a Universal Health Visiting Offer[9], the standard service when there are no concerns. She arranged a future meeting with mother to complete the 6-8-week post-natal depression check, this was good standard practice, and she advised mother on other post-natal support and the checks that were required via the GP Practice.

Post-mortem forensic evidence suggests that the first of Grace's injuries, caused by shaking, may have occurred around this time.

4.20 Four days later, (Grace 16 days old) mother attended the GP practice, without Grace. She was seen by a GP who had not previously met her. Mother was very stressed because of divorce proceedings. She was tearful, had poor sleep and poor appetite. However, she reported that she was managing the care of Grace and that Grace's father was supportive. *(Hindsight evidence gained through the criminal investigation shows that at the time Grace's mother in fact thought that Father was not being supportive.)* Because of the reported stress from the divorce the GP referred her to peri-natal psychiatry (at a different hospital to where Grace was born) and advised her to use the Citizens Advice Bureau.

4.21 A Midwife saw Grace and mother for the last time when Grace was 21 days old. Grace was now above her birth weight and appeared well. Grace's mother was considering ceasing breastfeeding and was given information about breastfeeding support groups. They were discharged from the Midwifery Service to the care of the GP and Health Visiting Service.

4.22 The Community Midwives had provided post-natal after care for 17 days. Throughout the contacts there were no major concerns about Grace, or about her care and she was noted to be well. During these contacts Routine Enquiry was not undertaken as would have been expected. The Protocol required this on at least two occasions.

4.23 Three days later, when Grace was 21 days old, her mother and father brought her to the GP Practice for the first time. Grace was not yet registered there as a patient. The clinical notes for Grace were made on mother's record, therefore. Grace had a discharge from the left eye but was able to open it. The GP took a swab of the discharge for testing. There was no reason for a complete examination at that visit. Mother mentioned that four tyres had been slashed on Grace's father's vehicle.

4.24 Mother also reported to the Police that the tyres had been slashed in an alleged ongoing local dispute. Father did not wish to pursue the matter. The next day mother called the police again alleging that she and Grace's father had been threatened by a member of the community. Police arrested the suspect who denied the incident. There was insufficient evidence to proceed. Police had no concerns about Grace but advised Children's Social Care of the incident as Grace was in the household.

4.25 No practitioner saw Grace before her collapse after this date.

[9] National Child Heath Pathway - Pathways - NHS Healthy Child Programme
Health visiting and midwifery partnership – pregnancy and early weeks (publishing.service.gov.uk)

4.26 Children's Social Care assessed the information from the Police, noting that there were unwitnessed allegations and counter-allegations about a dispute with a local community member regarding damage to vehicles, a verbal altercation and threat of violence. The Police had no concerns about Grace's care or welfare and noted that she appeared to be fit, clean and healthy. The Children's Social Care (MASH) Manager decided that as the family was not known to Merton Children's Social Care, and as the parents had acted appropriately by removing themselves and Grace from the alleged threatening situation that there was no role for Social Care and that the case would be closed, and a letter be sent to the parents signposting local services. There is no record that the letter was sent.

4.27 Two days later, in the last week of August the GP surgery left messages for Grace's mother about the eye swab but had no response.

Conclusions

4.28 Few services had contact with Grace or her parents prior to her death. The pregnancy and post-natal services offered were routine and appropriate for Grace's mother's age and situation and her reported worries about foetal development and post-natal worries about feeding. Standard welfare and safeguarding screening questions were appropriately asked; but for Routine Enquiry about domestic abuse, not as often as protocols required. Grace's mother was asked on two separate occasions (by a Midwife and several months later by the Health Visitor) whether she had had any experiences of domestic abuse and replied on both occasions that there were no concerns.

4.29 She had separately raised concerns with the GP Practice about her own emotional health, relating to work-related stress in pregnancy, her impending divorce and an alleged community dispute and threats.

4.30 Grace's mother was assessed by Midwifery, Health Visiting, and the GP Practice as able to care for Grace appropriately. There was no information which would have led to doubt mother's responses. She was seen as responsive to advice. There were no apparent grounds for concern.

4.31 There had been no concerns about Grace and her development beyond initial breastfeeding difficulties, which are common, and which were seen to be improving; she was gaining weight. When her weight was noted as a possible concern the Midwife continued to monitor and advise appropriately until there was sufficient improvement; this was good practice.

4.32 Grace's father was present at the birth. Midwifery and Health Visiting Services enquired about him. He was in the home for the first post-natal Midwifery visit but did not take active part. There may be a recording issue about noting when fathers do or do not attend ante-natal services as the records are not clear.

5 Grace's death – age one month

5.1 At the beginning of September Grace was found lifeless by her parents in the early hours. The Ambulance Service was called. Paramedics resuscitated her at the scene, but she was in cardiac arrest on arrival at the Emergency Department. ED staff re-established a heartbeat, with difficulty. Scans showed subdural and subarachnoid bleeds as well as possible historic bleeding on the brain, of differing ages. There was also unilateral retinal haemorrhage. These were initially assessed as probably non-accidental.

5.2 Joint child protection procedures were initiated by the Police and Children's Social Care.

5.3 The following day it was agreed that the life support system would be switched off and Grace died.

5.4 Extensive post-mortem examinations showed that apart from the injuries which led to her death Grace's health and development were normal and there were no underlying natural causes which could explain her death.

5.5 *The forensic pathology evidence showed the cause of death was assessed as* ***traumatic brain and spinal cord injuries****. Older, healing, brain injuries showed trauma probably of approximately two weeks' duration. There was evidence of injuries to Grace's ribs of various ages which included recent fractures, probably at the same time as, and linked to, the final traumatic brain injury. There were also rib fractures of 2-4 days duration and other rib fractures between 5-10 days prior to death.*

6 Grace's Mother's and Father's Involvement in this Review

Grace's Mother and Father were invited to take part in the Review. The purpose of their involvement would have been to seek their views and learn any lessons from their perception of the services that they were offered, not as part of any forensic investigation for the criminal proceedings.

They did not respond to the invitations.

7 Lessons from the Practitioners

7.1 By the time of the review some of the few Practitioners who had had direct contact with the family were no longer available. A Learning Focus Group was convened in September 2020, with two of the original practitioners (a Midwife and a Practitioner from the GP Surgery); plus representatives of the Clinical Commissioning Group - CCG, the Midwifery Service, the Health Visiting Service, the Police, Children's Social Care, and the Local Safeguarding Partnership. These additional representatives had not had direct contact with the family but understood the local practice and had had access to relevant records.

7.2 The purpose of the Focus Group was to learn from the Practitioners' direct experience of the case and from their wider experience of how universal ante-natal and early post-natal services are provided to families and whether there are any intrinsic systemic lessons. It must be noted that

the Group met three years after Grace's death. The conversation covered the provision three years previously and how services had developed since.

7.3 The **National Child Safeguarding Practice Review Panel's**[10] **Thematic Review into Non-Accidental Injury in Under Ones** was under way and questions from that review were included in the group discussion.

7.4 The Focus Group was held during the time of Covid 19 and some of the practices/services described had been temporarily suspended because of the response to the pandemic. More of the Midwifery contacts were having to take place remotely, by phone.

Issues arising from the Group discussion included:

7.5 **Including Fathers / Carers / Men** Grace's father had not been involved in ante-natal care provided by local Midwifery Services but was present at the birth. He was in the home for the first midwifery post-natal visit but did not take an active part. This raises the question about how services can be made more accessible to and inclusive for fathers and how they can be pro-actively encouraged to become involved.

7.6 Regarding the **times of services and their availability** to men who are at work it was noted that the local Midwifery Services can usually offer appointments in evenings and at weekends. This may be important for self-employed parents. The local Service has an open-door policy for fathers, including at weekends. There has also been provision of some parenting classes aimed specifically at fathers. Fathers have been encouraged to stay in hospital overnight when this is possible. (This was not the case in the pandemic however.)

7.7 It was noted **that fathers had been attending Midwifery Services more and more** and it was felt that this was now more common; indeed, it was now noticeable when fathers were not present.

7.8 An unintended consequence of fathers being present more often is the **challenge to making Routine Enquiry** about possible domestic abuse and having to try to create a space where the mother can be seen alone.

7.9 There is a necessary **focus on mothers and their own health** rather than on fathers. The Midwifery Booking Appointment session has several important tasks, including physical assessments and blood tests, as well as history taking. It can be a challenge to fit all this into the hour allocated. This is a system resource issue.

7.10 When fathers are not present a question arises about **how fathers can be advised and communicated with**. Where **Leaflets** are used as part of the repertoire for helping (new) parents and when the father is not present **the mother has to become a conduit for the information**. It was noted that in this case several leaflets were given but it was not known if father had seen any of them and that given that English was not his first language whether the printed word is the most useful medium.

[10] National Child Safeguarding Practice Review Panel – explanatory note

7.11 Wider experience was shared about alternative approaches to involving fathers. **An App for Fathers** for mutual support was noted as a useful medium where men can get advice and support from other fathers, an example is **DadAF**[11]**.** Further web research has shown other examples such as the **Dads to Dads** Website[12]. These were not promoted locally.

7.12 **Helping parents (mothers and fathers) think about and prepare for the impact of incessant crying and how to respond.** Given that Grace was understood to have been shaken on three separate occasions the group was asked to think about what advice is given ante-natally or post-natally about the impact of incessant crying on tired parents, as a possible trigger to shaking. This issue was covered briefly in the local ante-natal parenting classes, but it was thought that it probably received too little attention and not enough was discussed. *(Grace's parents had not attended these classes).* It may be particularly important for first time parents. There was a question about whether the impacts of incessant crying were different for men and women. A father may see, hear, and feel the distress for the baby but may also see the impact on his partner who may be feeling that she is not coping and who sees herself as the primary carer and so expected to pacify the baby. Arguably more research is needed in this area.

7.13 It was noted that both the local Midwifery Service and Health Visiting Service are now giving out the **ICON Leaflet about crying**[13]. This raises the question about **the efficacy of Leaflets** and whether there has been sufficient research in this area and whether other forms of media would suit some mothers or fathers. This issue is also likely to be influenced by age, gender, class, culture, language, and capacity. It was agreed that best practice was not to rely on leaflets alone but also to involve conversation, if there is time. Although it was felt that there is rarely enough time.

7.14 **Access to background checks on parents and risk** It was noted that for Baby Grace ante-natally and post-natally there were no suggestions, in this case at the time, of the need for health services to check with other services (such as social care or police) about parental background. Such checks must be proportionate and unless there are clear welfare concerns a check would not be routine and would require parental consent. There was no suggestion from what was shared or observed at the time of any safeguarding concern which would suggest parental consent for checks should be sought.

[11] **DadAF APP** The idea and concept was born from the feeling of isolation many men experience, and a clear lack of support and guidance for Dads around the world. https://www.dadaf.co.uk/

[12] **From Dads to Dads:** Website real-life experiences and real-life useful facts. Information dads want laid out simply by experts in that field and information-packed articles by dads for dads sharing their experiences. http://www.fromdadstodads.org.uk/ *The section for Health Care Professionals has interesting feedback from Fathers on Communication by Health Care Practitioners http://www.fromdadstodads.org.uk/for-health-care-professionals/communication/*

[13] **ICON** ICON is a programme that provides information about infant crying and how to cope. https://iconcope.org/

8 Lessons from the Review

8.1 Grace and her parents were assessed as requiring only universal services. From the information that was available to the practitioners at the time - seen by this review - this was the correct assessment.

8.2 In the short period that Grace lived there was no need for her to be fully examined by a health practitioner. She was seen by the Health Visitor, GP, or a Midwife but there were no concerns about her that would have warranted a full assessment. Her initial weight loss and slow weight gain, her tongue-tie and later her sticky eye were noted and followed up appropriately. When she was weighed there was no physical evidence that any practitioner could have seen at the time that would have indicated that she had been shaken or injured. This information only became available by hindsight and rigorous forensic examination.

8.3 Grace's mother was twice asked routinely whether she had experienced or was experiencing any domestic abuse – not all services routinely ask this. At the time she said that she had not experienced domestically abusive behaviour.

8.4 When Grace's mother described different stresses, she felt she was offered appropriate advice and support, including a referral to psychiatric support services. She reported being less stressed when she had ceased working. Later, even when under the acute stress of the divorce proceedings, she reported that she was managing Grace's care well. There was no reason to suspect that this was not so.

8.5 When the local dispute, slashing of tyres and an altercation came to light appropriate action was taken by Police, advice was given, and the matter was referred to Children's Social Care as a baby was involved; however, this was not a domestic dispute and there was no harm to or perceived possible harm to Grace from within her family. The decision by Social Care not to offer a direct service was appropriate. However, no trace has been found of the intended letter which was to be sent. Given Grace's death soon after this decision it is assumed that the letter was not sent.

8.6 After Grace's fatal collapse when the Ambulance Service was called it was noted that Grace's parents "may have been drinking". There was no prior evidence to suggest that this was an underlying problem and if it was, it was not known to practitioners at the time.

8.7 This review has shown that the services worked as they should have done by screening during pregnancy and after birth to decide if raised levels of support or monitoring were required. From the clinical observations of Grace and from mother's accounts the decisions made about services were child-centred and mother-centred, and appropriate. There was no evidence suggesting a need for enhanced support services above universal provision.

Are there lessons from this case which raise questions for local services?

Supporting parents in managing triggers which may lead to shaking a baby and to Abusive Head Trauma

8.8 Hindsight, from the forensic pathology assessment indicates that Grace was probably subject to three separate episodes of shaking in her short life; the last episode leading to brain trauma that directly caused her collapse and then death.

8.9 Grace's mother was a first time and more mature mother. She was experiencing additional stress from her impending divorce and from a community dispute. There was no evidence that she or Grace's father were experiencing any mental illness. Information shared in the trials suggests that there were tensions in the parental relationship after Grace's birth. These were not shared with or known to practitioners at the time.

8.10 Research[14] suggests that the most common causes of shaking incidents are parent or carer frustration in which the baby's crying may be a factor; unpredictability of the crying rather than its intensity may also be a dynamic. Difficulties in feeding can be a cause of such crying and additional parental frustration. The frustration can include guilt in not being able to respond to the baby's needs. Lack of parental sleep can also be an important factor in parental reaction. Neither Grace's mother or father raised direct concerns about crying or its impact on them.

8.11 A question arises about how inexperienced parents are supported and advised about the impact of crying in the ante-natal and post-natal advice and care that they are given. Grace's mother sought help appropriately throughout her pregnancy and in the month of Grace's life. She was given relevant leaflets by Midwives and Health Visitor, including one on crying. The Practitioner response to this review was that overall, there is not enough time to go into this area in depth in the face-to-face meetings.

8.12 It is understood that Grace's mother would have been invited to attend local or hospital-based ante-natal classes from 17-weeks with the intention that the father or a supporter should also be invited to attend. These are, however, voluntary. Mother and father did not attend any ante-natal parenting classes arranged by the local Midwifery Services. Crying would have been covered but not in a lot of detail. Now a leaflet would be given in addition.

8.13 **Recommendation 1** The Merton Safeguarding Children Partnership should ask the CCG to review the effectiveness of the local approaches taken across ante-natal and post-natal care to support parents in responding to crying by babies.[15]

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[14] **A study describing mothers' opinions of the crying behaviour of infants under one year of age**: Nash, Morris and Goodman; April 2008; **Child Abuse Review** Vol 17 (3) May 2008, pages 191 – 200 **https://onlinelibrary.wiley.com/doi/10.1002/car.1017** *At the time of this article the phrase Shaken Baby Syndrome was common; now the phrase Abusive Head Trauma is used.*

[15] See similar work done by Hampshire and Manchester Safeguarding Children Partnerships and the ICON Campaign: https://www.hampshirescp.org.uk/toolkits/abusive-head-trauma/resources/research-policies-and-procedures/

https://www.manchestersafeguardingpartnership.co.uk/resource/abusive-head-trauma-advice-for-all/

The purpose of this action would be to ensure that advice is given to parents on the management of crying and the parental reaction to it. Leaflets alone may not be sufficient.

8.14 **Recommendation 2** The Merton Safeguarding Children Partnership should consider sharing the current resources used by the Local Merton Provider Trust for Health Visiting to support new parents so that they can be accessed by other professionals who may also be part of a network supporting new parents, such as Children's Centres, Schools and Social Care.[16]

This would ensure that all services supporting families with babies have access to the best advice and can support parents and back up the advice from Health Visiting and Midwifery.

Reaching and supporting fathers

8.15 Grace's father was not "absent". He was known about and seen on several occasions. It was understood that he had moved into mother's home by the time of Grace's birth. He does not appear to have attended any of the ante-natal midwifery care. Later information suggests that he had attended attend NCT ante-natal classes, but it is not clear if this was for Grace's birth or an older child. He was present for the birth and was at home for the first post-natal midwifery visit – although he did not take part. He did, however, attend with mother when Grace was brought to the GP at 21 days old.

8.16 Hindsight, from the trials, suggests that father was not always at home in the first few weeks and that there were tensions between him and Grace's mother because of his absence. This was not shared with the practitioners at the time; they could not have known.

8.17 He was not a first-time father; he had older children. This was not known by the current professionals and no history was taken of his involvement in their care.

8.18 The contemporaneous assessments are not clear about how much he planned to be or was a hands-on father. On the occasions he was seen he was noted to be concerned or caring appropriately. He was not given any parenting information or advice directly by Midwifery or Health Visiting. A systems question is, therefore, that when fathers are not present in ante-natal or post-natal support: How do they receive relevant advice or information? The mother becomes the conduit.

8.19 It is still common for fathers not to be part of ante-natal or post-natal support services. However, this review learned that locally fathers were (pre-pandemic) increasingly more directly involved in ante-natal care services. Their absence does not necessarily mean that they are not interested or that they make poor parents. The records do not show how Grace's father's role as a co-carer was explored through discussion with Grace's mother or what attempts were made to involve him directly and offer advice about parenting. His self-employed status and a possibly

[16] The Local Merton Provider Trust for Health Visiting has informed this review that all Health Visitors are now trained to use standard resources from ICON https://clch.nhs.uk/services/new-baby-and-parent-resources This includes the ICON Leaflet: **Infant Crying and How to Cope** https://clch.nhs.uk/application/files/6515/9256/7900/ICON_LEAFLET_2020.pdf

different cultural approach may have been dynamics which affected his involvement with professionals, but these points were not explored.

8.20 From the little information shared about him by Grace's mother there was nothing to suggest he was a risk to a baby. When the Police briefly saw him with Grace, they had no concerns about her, or him.

8.21 Although not in fact absent, he was "absent" to the professionals. Is this a commonly accepted systemic issue - that fathers cannot be reached if they are not available for the way services are provided? He was at home on one of the visits, however.

8.22 The Royal College of Midwives: **Top Tips for Involving Fathers in Maternity Care**[17] sets out practice advice for reaching and involving fathers. The Local Hospital ran separate ante-natal groups for fathers with a local charity. This review has raised the question of how fathers can be signposted to self-help groups via Apps and the Web.

8.23 **Recommendation 3** The Merton CCG should ask the Providers of local Maternity and Health Visiting Services to review the approaches taken to include fathers; including the use of leaflets or other media aimed specifically at men.[18] (See paragraphs 8.15 – 8.22)

This would enable best practice to be considered and protocols to be reviewed to ensure opportunities are taken to involve fathers as much as possible.

Use of Routine Enquiry about domestic abuse

8.24 Grace's father had one historic police caution for common assault against a previous partner. It is unlikely that Grace's mother would have known about this as it predates their relationship by several years.

8.25 Grace's mother was asked once by a Midwife about any experience of domestic abuse (Routine Enquiry) although the Trust policy for Midwifery was that a mother should be asked on two occasions. At the time it was not current practice to record why such an enquiry had not been undertaken. The Trust has since implemented a system whereby a Midwife must record the reason for not asking at a booking appointment on both any handheld records and on the central (E3) electronic record system. It is best when this is done in a professional relationship by the Mother's named midwife.

8.26 The Review has noted that an observed increase in the number of fathers involved with ante-natal and post-natal services has had a knock-on effect to make it harder for practitioners to see women alone to ask about domestic abuse (routine enquiry).

8.27 The Hospital Trust provides regular training and refresher training for midwives on this issue. This includes the opportunity to explore the challenges to asking women about domestic abuse and midwives' own confidence in raising the issue. A Trust Audit of Midwifery Training in Domestic

[17] https://www.rcm.org.uk/media/2345/top-tips-for-involving-fathers-in-maternity-care.pdf
[18] https://www.iriss.org.uk/resources/insights/good-practice-fathers-children-and-family-services

Abuse across 2019, reported in March 2020 (after Grace's death but currently relevant). Self-evaluation questionnaires were used.

8.28 Responses about overcoming possible barriers to asking about domestic abuse were:

- Personal confidence about being able to see women alone – even if they had come with a partner or friend; 55% of respondents stated that they felt very confident in seeing the woman alone, a decrease compared to 62% in 2018.
- 65% of staff indicated they felt confident and able to ask a woman about Domestic Abuse, compared to 71% in 2018.
- This potentially shows that a sizeable number of staff do not feel confident in raising the issue of Domestic Abuse with women, if the numbers can be assumed across the workforce.

8.29 The Provider Trust for Health Visiting has agreed to evaluate its domestic abuse training for health visitors in a similar way.

8.30 On the two occasions that she was asked, once ante-natally by a Midwife and once post-natally by the Health Visitor, Grace's mother said that there was no concern about domestic abuse. Given her general responsiveness and co-operation, there was no reason to doubt her answers. (Fear of repercussions could be a factor in how willing or open a woman would be in reporting abuse.) There were no other indicators from other services at the time (GP or Police) of domestic abuse. As there were no apparent safeguarding concerns or known history there was no reason to seek information from any other agency about possible domestic abuse. *It has come to light (through the trials) that there were tensions in the parental relationship after Grace's birth but there is no indication that there was physical domestic abuse.*

8.31 The Hospital Trust is already responding to this issue of supporting Midwives in best practice in asking women about risk from domestic abuse and signposting them or referring them to services where required. The Trust works with the **IRISi Organisation**[19] to improve recognition of and responses to gender-based violence.

8.32 There is a systems question about whether this issue of a lack of competence and confidence in frontline health workers (or other professions) asking about domestic abuse is more widespread. The Royal College of Midwives quotes research in Australia[20] which suggests that competence and confidence are issues to be addressed. If that also applies to the UK, Merton Safeguarding Children Partners may wish to flag this issue to the RCM, the Department of Health, and the National Panel for Child Safeguarding Practice Reviews for further research. It should be noted, however, that the local arrangements provide a specialist Lead Midwife for Safeguarding to provide advice and training.

19 https://irisi.org IRISi works to ensure gender-based violence is consistently recognised and addressed to improve the healthcare response by working to develop innovative, evidence-based health interventions for those affected by gender-based violence.

20 **RESEARCH: SUPPORTING MIDWIVES IN ASKING WOMEN ABOUT DOMESTIC VIOLENCE; Baird, Creedy, Saito, Eustace; March 2018** https://www.rcm.org.uk/news-views/rcm-opinion/research-supporting-midwives-in-asking-women-about-domestic-violence/

8.33 **Recommendation 4** The Hospital Trust should continue to report the outcome of its annual review of Midwives' training in domestic abuse to the Merton Safeguarding Children Partnership in order to monitor levels of confidence and competence.

The Health Visiting Provider Trust should also be asked to report on this.

These actions will enable the CCG and the Merton Safeguarding Children Partnership to have confidence in the levels of skill in Midwifery and Health Visiting in relation to assessing risk of domestic abuse and to consider if the lessons from the annual evaluation may be applicable to practitioners in other services.

The Merton Children Safeguarding Partners may wish to consider asking other local services to report on staff training and staff competence and confidence in undertaking (routine) enquiries about domestic abuse.

The Merton Safeguarding Children Partners may wish to flag this issue to the RCM, the Department of Health, and the National Panel for Child Safeguarding Practice Reviews for further research or guidance.

Continuity in post-natal care across Midwifery and Health Visiting

8.34 In this case the routine notifications about the pregnancy and birth were shared with the Health Visiting Service and GP. The Community Midwife continued post-natal care until day 21 which overlapped with the Health Visitor's New Birth Visit. Both services saw Grace and her mother on day 12, but separately. The Public Health and Department of Health Guidance: **Health Visiting and midwifery partnership – pregnancy and early weeks**[21] (undated, possibly 2014) sets out a pathway to provide integrated and joined up care across these services to enable improved parental experiences. Included in the guidance is a joint handover between the midwife and health visitor. That did not happen in this case and it appears that such joint handovers are rare as there is not time to do that for every baby, especially where there are no concerns about the baby or the quality of parental care. There was confidence among the practitioners and managers that where there are concerns information is shared with the Health Visitor. Good practice would be for the Midwife to inform the Health Visitor if they are involved beyond day eleven post birth.

8.35 This raises questions about how an incoming health visitor can fully complete an assessment of the mother and the baby's needs and where to place them on the **Healthy Child Programme Pathway.** How does any information, such as involvement in ante-natal classes, involvement of fathers and any previous responses to **routine enquiry** pass from the midwifery service to health visiting? It seems that it is assumed that where there are concerns, they will be passed across the services, but it is not clear how this is ensured or audited.

[21]Public Health & Department of Health Guidance: **Health Visiting and midwifery partnership – pregnancy and early weeks** (2014)
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/465344/2903819_PHE_Midwifery_accessible.pdf

8.36 **Recommendation 5** The CCG should consider commissioning a review of joint protocols and practice in the handover and transfer of information between the Midwifery and Health Visiting Services and GPs to ensure that best practice is in place within available resources; particularly when the Midwifery contact with mother and baby continues beyond the Health Visitor New Birth Visit.

This will ensure that Health Visitors have access to fuller information with which to make the assessment of which Pathway to use to support parents.

Public Awareness and Practitioners knowledge of and use of Clare's Law

8.37 Grace's father had a caution for assault on a previous partner; this was evidence of previous domestic abuse. It is unlikely that Grace's mother was aware of this. A question arises about how aware members of the public are of '**Clare's Law'**[22]- the **Domestic Violence Disclosure Scheme,** the right to ask the Police for information about a partner's history of domestic abuse. How well is this right promoted? It is signposted on the Merton Council website but is more likely to be used by women already experiencing abuse and looking for help. As a preventative resource there is a question about how well it is promoted for those who may be embarking on new relationships and how practitioners use it in their everyday work.

8.38 A Child Safeguarding Practice Review in another London area (not yet published in April 2021) has shown that Practitioners across a wide range of family services were unaware of "Clare's Law" or how to use it in their practice. It is covered in the London Child Protection Procedures[23].

8.39 Grace's mother and father were already in a relationship when they came to the attention of the universal services through the pregnancy. It may not, therefore, have been appropriate for a practitioner to have signposted the Domestic Violence Disclosure Scheme to Grace's mother.

8.40 However, overall, the case raises the question about how aware women are of their right to ask about a partner's possible previous domestic abuse. How well is it publicised by local services, for example, in waiting areas, through leaflets, in health promotion, community safety awareness and other processes?

8.41 **Recommendation 6** The Merton Safeguarding Children Partnership may wish to commission a review of the promotion of awareness of 'Clare's Law' within the local community and a parallel review of how it is included in professional procedural guidance and the training of key practitioners working with women.

Lessons from the Trial / Hindsight

[22] **Clare's Law: Domestic Violence Disclosure Scheme** https://www.met.police.uk/advice/advice-and-information/daa/domestic-abuse/alpha/request-information-under-clares-law/

[23] **Domestic Abuse Disclosure Scheme – Clare's Law**: London Child Protection Procedures 2020 https://www.londoncp.co.uk/chapters/sg_ch_dom_abuse.html#dom_viol

8.42 Information from the trial, which was not previously available to this review, revealed that there was increasing tension in the parental relationship after Grace's birth; at times father stayed away from the home; mother and father were said to have been drinking regularly, although the level of alcohol being drunk was disputed in the trial. Grace was described by mother as a baby who "slept well". It was not possible at trial to establish who had caused the injuries to Grace.

8.43 Mother was asked by practitioners, at the time, about the parental relationship and about drinking but there was no information from her response to suggest that Grace was at risk. Mother's education and social status and her general responses gave confidence in the information she gave.

9 Recommendations

If these recommendations are accepted by the Merton Safeguarding Children Partners, they should be made into an Action Plan to carry them forward with clear outcomes, timescales, leadership, and monitoring.

Supporting parents in managing triggers which may lead to shaking a baby and to Abusive Head Trauma

9.1 **Recommendation 1** The Merton Safeguarding Children Partnership should ask the CCG to review the effectiveness of the local approaches taken across ante-natal and post-natal care to support parents in responding to crying by babies.[24] (See paragraphs 8.8 – 8.12)

The purpose of this action would be to ensure that advice is given to parents on the management of crying and the parental reaction to it. Leaflets alone may not be sufficient.

9.2 **Recommendation 2** The Merton Safeguarding Children Partnership should consider sharing the current resources used by the Local Merton Provider Trust for Health Visiting to support new parents so that they can be accessed by other professionals who may also be part of a network supporting new parents, such as Children's Centres, Schools and Social Care.[25] (See paragraphs 8.8 – 8.12)

This would ensure that all services supporting families with babies have access to the best advice and can support parents and back up the advice from Health Visiting and Midwifery.

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[24] See similar work done by Hampshire and Manchester Safeguarding Children Partnerships and the ICON Campaign: https://www.hampshirescp.org.uk/toolkits/abusive-head-trauma/resources/research-policies-and-procedures/

https://www.manchestersafeguardingpartnership.co.uk/resource/abusive-head-trauma-advice-for-all/

[25] The Local Merton Provider Trust for Health Visiting has informed this review that all Health Visitors are now trained to use standard resources from ICON https://clch.nhs.uk/services/new-baby-and-parent-resources This includes the ICON Leaflet: **Infant Crying and How to Cope** https://clch.nhs.uk/application/files/6515/9256/7900/ICON_LEAFLET_2020.pdf

Reaching and supporting fathers of babies

9.3 **Recommendation 3** The Merton CCG should ask the Providers of local Maternity and Health Visiting Services to review the approaches taken to include fathers; including the use of leaflets or other media aimed specifically at men.[26] (See paragraphs 8.15 – 8.22)

This would enable best practice to be considered and protocols to be reviewed to ensure opportunities are taken to involve fathers as much as possible.

Training Practitioners in assessing possible risk from domestic abuse – ensuring competence and confidence

9.4 **Recommendation 4** The Hospital Trust should continue to report the outcome of its annual review of Midwives' training in domestic abuse to the Merton Safeguarding Children Partnership in order to monitor levels of confidence and competence. (See paragraphs 8.24 – 8.32)

The Health Visiting Provider Trust should also be asked to report on this.

These actions will enable the CCG and the Merton Safeguarding Children Partnership to have confidence in the levels of skill in Midwifery and Health Visiting in relation to assessing risk of domestic abuse and to consider if the lessons from the annual evaluation may be applicable to practitioners in other services.

The Merton Children Safeguarding Partners may wish to consider asking other local services to report on staff training and staff competence and confidence in undertaking (routine) enquiries about domestic abuse.

The Merton Safeguarding Children Partners may wish to flag this issue to the RCM, the Department of Health, and the National Panel for Child Safeguarding Practice Reviews for further research or guidance.

Public Awareness and Practitioners knowledge of and use of Clare's Law
Continuity in post-natal care across Midwifery and Health Visiting

9.5 **Recommendation 5** The CCG should consider commissioning a review of joint protocols and practice in the handover and transfer of information between the Midwifery and Health Visiting Services and GPs to ensure that best practice is in place within available resources; particularly when the Midwifery contact with mother and baby continues beyond the Health Visitor New Birth Visit. (See paragraphs 8.34 and 8.35)

This will ensure that Health Visitors have access to fuller information with which to make the assessment of which Pathway to use to support parents.

Public Awareness and Practitioners knowledge of and use of Clare's Law

[26] https://www.iriss.org.uk/resources/insights/good-practice-fathers-children-and-family-services

9.6 **Recommendation 6** The Merton Safeguarding Children Partnership may wish to commission a review of the promotion of awareness of 'Clare's Law' within the local community and a parallel review of how it is included in professional procedural guidance and the training of key practitioners working with women. (See paragraphs 8.37 – 8.40)

10 Appendices

10.1 Terms of References (Extract Summary)

The review should:

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and MSCP.
- Examine inter-agency working and service provision for the child and family.
- Determine the extent to which decisions and actions were child focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources.

The review should have particular regard to the following:

- Was previous relevant information or history about the child and/or family members known and taken into account in professionals' assessment, planning and decision-making in respect of the child the family and their circumstances?
- How did that knowledge contribute to the outcome for the child?
- Did any of the professional network supporting the parents before and immediately after the birth of Baby Grace have any concerns regarding the capacity of the parents or other factors which could impact on her care? Were these concerns shared?
- Were there obstacles or difficulties in this case that prevented agencies from fulfilling their duties? This should include consideration of both organisational issues and other contextual issues
- Did the assessments take into consideration any parental history relating to domestic abuse (either as a perpetrator or a victim)? Did the assessment take into account any history related to domestic abuse and the physical abuse of children? Did any assessment take into consideration the impact of parental mental health or parental substance misuse?
- How was the parenting capacity of both parents assessed?
- How were family and environmental factors taken into account in assessments and addressed in the work with this family?
- Were the statutory duties of all agencies fulfilled?
- How well was information shared between statutory agencies and other relevant agencies?
- What are the practice implications of this case for the MSCP with regards to developing responses to address the 'trigger trio'?

10.2 Review Panel Membership

Lead Independent Reviewer: Malcolm Ward, B.Soc.Sc & Master of Social Work, Independent Social Worker and Child Protection Consultant

Review Panel Chair: Associate Director of Safeguarding, Community Healthcare NHS Trust
Panel Members:
Detective Sergeant, Specialist Crime Review Group, Metropolitan Police
Domestic Violence & Abuse Coordinator, London Borough of Merton
Merton CCG Designated Nurse
Named Nurse for Safeguarding for the Acute Hospital Trust
Named Midwife for Safeguarding for the Acute Hospital Trust
Service Manager, London Borough of Merton Children's Social Care

Manager, Merton Safeguarding Children Partnership
Administrator, Merton Safeguarding Children Partnership

None of the Panel Members had had a direct role in the management of the case

10.3 Additional Reading and Useful Resources

Handle with care: How to keep your baby safe; NSPCC, Need to know guides.
https://learning.nspcc.org.uk/media/1112/handle-with-care-guide-keeping-baby-safe.pdf

The RCM standards for midwifery services in the UK; The Royal College of Midwives; September 2016 https://uat.rcm.org.uk/media/2283/rcm-standards-midwifery-services-uk.pdf

Health Visiting Programme: Pathway to support professional practice and deliver new service offer: Health visiting and midwifery partnership – pregnancy and early weeks; Public Health England and Department of Health; 2014
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/465344/2903819_PHE_Midwifery_accessible.pdf

Infant crying and how to cope: Information for parents and carers: Babies Cry, You Can Cope!
https://clch.nhs.uk/application/files/6515/9256/7900/ICON_LEAFLET_2020.pdf

Special Issue: Abusive Head Trauma: Recognition, Response and Prevention; Child Abuse Review, May-June 2020; **Editors** Appleton and Sidebotham

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Malcolm Ward, B.Soc.Sc, Master of Social Work

Independent Reviewer

May 2021