CSCP
CROYDON SAFEGUARDING CHILDREN PARTNERSHIP

‘Eva’
Child Safeguarding Practice Review

Date: November 2023

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Contents

1. Introduction by the independent author and rationale for the Local Child Safeguarding Practice Review

This Local Child Safeguarding Practice Review (LCSPR) was commissioned by Croydon Safeguarding Children Partnership (CSCP) and is in respect of Baby Eva. Working Together (2018), contains the statutory guidance setting out that when a child has been seriously harmed or has died as a result of neglect or abuse, the Local Safeguarding Children Partnership should conduct a Rapid Review.

A Rapid Review for Baby Eva was undertaken in July 2023. The rapid review in concluded that a Local Child Safeguarding Practice Review (LCSPR) should be carried out. Reviews of serious child safeguarding cases are not conducted to hold individuals, organisations or agencies to account, as there are other processes for that; the purpose of a LSCPR is to:

- Identify improvements to be made to safeguard and promote the welfare of children.
- Seek to prevent or reduce the risk of recurrence of similar incidents.
- Identify local learning that has a wider importance for all practitioners working with children and families and for the government and policymakers.
- To understand whether there are systemic issues, and whether and how policy and practice need to change; this is critical to the system remaining dynamic and self-improving.

Names have been changed throughout the report to protect the identity of individuals.

The final report has been authored by Dr Amanda Boodhoo who was independent of the case with no actual or perceived conflict(s) of interest.

2. Summary of circumstances leading to the review

The report reviews the case of Baby Eva who at the age of almost four months was taken to Croydon University Hospital (CUH) Emergency Department (ED), by both parents. The parents reported that she had pain in her right arm.

Examination revealed a spiral fracture to her right upper arm and mottling to her left arm.

A full skeletal survey revealed multiple fractures, including rib fractures and other fractures described as being of different ages, one of which was at least one week old. There was also a query injury to Baby Eva's spine.

Baby Eva was placed in police protection and on discharge from hospital was placed with foster carers. Both parents were arrested following the identification of Baby Eva's injuries and remain under investigation. Baby Eva's mother has since made

allegations of domestic abuse perpetrated by Baby Eva's father, which is also the subject of an ongoing police investigation.

In undertaking the review, information provided revealed that Baby Eva's father is care experienced and had been described through the MARAC process as a 'high risk' perpetrator. The MARAC process refers to a meeting that focuses upon multi-agency risk assessment and management, where professionals share information on high-risk cases of domestic violence and abuse and put in place a risk management plan.

At the time Eva's father was considered as part of the MARAC process he was in a relationship with another female with whom he had a child, who was 8 weeks old.

3. A Picture of Baby Eva

Eva was described by professionals as an "alert little girl, who was settled and made good eye contact with those who interacted with her". She was born by Caesarean section and is described as being of mixed heritage (White/Caribbean).

4. Learning and improvement actions from the rapid review

During the rapid review process, learning was established through the robust consideration of agency contributions.

The learning from the rapid review was mapped against learning from other recent reviews. This includes specific work relating to information sharing, in recognition that there are inconsistencies across the partnership as to when and what information can be shared.

Croydon has recently undertaken a joint LCSPR with another LCSP (Baby Cora) where a similar aged child, presented at hospital with injuries and where information sharing prior to the presentation was poor.

Other areas of learning being taken forward from the rapid review by individual agencies include:

- Adapting existing practice within the maternity service (outside of Croydon) and the GP practice to ensure that the female is seen alone to undertake routine enquiry. This was an area of concern in this review as the partner was constantly present and there were concerns regarding his presentation and behaviour towards maternity staff and Eva's mother.
- The need to ensure that, when an adult presents as aggressive, information is shared with other professionals and safeguarding professionals are consulted.
- New staff within community health services to be made aware of information held on old community health records and the need to view these to identify relevant historical information.

In meeting with professionals throughout this review, It was evident that actions were being taken forward and the partnership is monitoring progress and the impact through their partnership governance structures. Where areas of learning are identified as part of this review, but it is evident they are already being progressed following the rapid review, no further recommendations will be made.

5. The LCSPR - Methodology and Agencies Involved

This review builds upon the learning identified through the rapid review process and focuses upon the lived experience of Baby Eva.

The scope of this review is the period from nine months prior to Eva's birth to the period immediately following the time when her injuries were identified (May 2022-June 2023). Significant events, needs and developments in the child or family's life prior to this beginning of the period will be summarised.

The information available from the rapid review was comprehensive and therefore the methodology I have adopted for this review is a focused approach. This means that I have concentrated on the specific issues identified in the terms of reference, set by Croydon Safeguarding Children Partnership, using the following stages:

I. A systems analysis drawing on summary information from agency records submitted for the rapid reviews and other relevant documents and or policies. This will support the identification of key practice episodes and analysis of the agency and multi-agency assessments and interventions and the rationale for them, assessed against relevant policy, guidance and professional standards of the time.

II. Conversations with relevant family members (if possible).

III. Conversations with practitioners and managers who were involved in the case.

IV. Triangulation of the information, providing the opportunity to test whether the good practice identified and any lessons about this case were/are more widely prevalent in the wider local safeguarding system.

V. To use the case to test how well identified lessons and improvements from previous and contemporaneous reviews are being implemented and making an impact.

The stages outlined have enabled triangulation of the information, providing the opportunity to test whether the work and any lessons about this case were/are more widely prevalent in the wider local or national safeguarding system.

The learning from these stages is summarised in this overview report, identifying key themes, areas of good practice, highlighting specific learning, and making recommendations for system-wide practice improvement.

The production of this local child safeguarding practice review has been overseen by members of the partnership.

The agencies and professionals who contributed to this review were:

- Croydon Children's Social Care
- Metropolitan Police
- Family Justice Centre (FJC)
- GP
- London Ambulance Services
- Croydon University Hospital & Health Visiting Service (Croydon Health Services)
- South London & Maudsley NHS Trust (SLaM)
- Croydon Housing
- Princess Royal University Hospital
- Probation Service
- Croydon Youth Justice Service

6. Key areas as the focus of the LCSPR

The Rapid Review in relation to Eva identified four key areas where there was potential for further learning. These have formed the key lines of enquiry within this LCSPR:

1. **Assessment of the impact of previous learning.** A previous review (Baby Cora 2022, currently unpublished) was undertaken by CSCP and another LCSP. This review found:
   a) There was an insufficient response within health services to recognising the evidence of non-accidental injury.
   b) There were deficits in information sharing from all agencies for Baby Cora

This review was asked to consider whether there is evidence of better practice in relation to Baby Eva?

2.The Impact of systems on the quality and response to information sharing. The Rapid Review process identified a number of instances in health services and the police where systems may have impacted on the quality and response to information sharing. This review was asked to consider whether systems impacted on decision making and risk management, whether there is a systems gap that requires further attention and whether there is evidence of systems issue prevalent in other agencies requiring a systems focused approach.

3. Responding to information about fathers and other children

The Rapid Review process identified, in common with other reviews, gaps in the quality of information sought and shared by agencies, specific to fathers, their history including any previous children and areas of risk such as the impact of being care experienced and/or domestic abuse. This review was asked to consider whether there was evidence of any information, specific to fathers, missing or not sought and whether, had this information been available, *it would have made a difference to the support offered to protect Baby Eva and what the barriers were to enable this information to be sought/available.*

7. Family Involvement

At the commencement of the review an initial letter and information leaflet was shared with both of Eva's parents. The letter informed the family that the review was taking place, explained the purpose and process and invited them to contribute. During the time the review was being undertaken there were ongoing police investigations. There was ongoing communication with the police and parents to try to facilitate family involvement but due to the police investigations it has not been possible for the author to meet with family members. The author has made every attempt to include evidence of the views of the family where these were recorded in the records of professionals.

8. Key Practice Episodes

The period that the review focuses upon is stated in the terms of reference as from May 2022 until June 2023. The information covering this period is presented as key practice episodes.

Period prior to May 2022 – Pre-conception period

This period was outside the scope of the review, but a summary of significant information is presented. Records seen as part of this review indicate that Eva's parents had been in a relationship for a relatively short time. Following Eva's injuries, Eva's mother reported to the police that they had been in a relationship "on and off for a year to a year and a half".

It appears both parents had lived in the Croydon area from childhood and were both known to a range of agencies including the 0-19 children's social care and police services. In addition, Eva's father was known to child and adolescent mental health services (CAMHS), probation and had been referred to Croydon Youth Justice Service in 2015, but as he missed numerous appointments, they were unable to undertake any assessment.

Eva's father attended a school for children with additional learning needs and is noted to have spent long periods of time out of education, those reasons included "being a danger to other students".

Eva's father's family have a significant history of social care involvement dating back to 1998, which includes concerns for Eva's father and his sister as children and the

children of Eva's paternal aunt, who are known to Croydon children's services and are currently subject to care proceedings. Eva's father is a care experienced person. He was in care to Croydon from June 2015 to July 2016. He continued to receive support from the Leaving Care Service until October 2020 when involvement of the Personal Advisor (PA) was ended. The impact of adverse childhood experiences (ACEs) in both Eva's father and his sister's early lives cannot be underestimated and needs consideration when working with "whole families".

Between 2014-21 Eva's father came to the attention of a number of police forces resulting in four convictions, one acquittal, two guilty findings, one caution and 13 no further action outcomes. The reasons for coming to the attention of the police include numerous battery offences, threats to kill, common assault, possession of a Class B drug, growing cannabis and failing to comply with community orders.

His last offence was in February 2019, prior to his relationship with Eva's mother. Although there were no recorded incidents of domestic abuse between Baby Eva's birth parents prior to her presenting at the hospital with injuries; a number of concerns arose re Eva's father's presentation, both antenatally and immediately postnatally which was concerning and led professionals to feel intimidated. If professionals felt intimidated, the lived experience of a new baby exposed to this needs to be carefully considered.

The history of assaults by Eva's father on others, includes assaulting his family members and his ex-partner, with whom he had a child when he was 16 years of age. This child, Eva's half sibling was subject to safeguarding processes and care proceedings, initiated with Eva's father's violent behaviour being a main contributory factor. At the time he was assessed by MARAC as a high-risk individual. Eva's father has no contact with his first child.

During this period there is reference to Eva's father being the victim of assault, including an assault involving Eva's father being pushed to the floor kicked in the head and stabbed.

In 2014 Eva's father was referred to CAMHS by the GP due to anger issues at school, self-harming and possible psychosis arising from delusional beliefs. It is recorded there is a family mental health history, (mother and sister have been diagnosed with bipolar disorder, paternal uncle has been "in and out of a mental hospital", and paternal great grandmother is said to have split personality syndrome). The school were reported to believe that Eva's father presented with signs of attention deficit hyperactivity disorder (ADHD), a condition that affects people's behaviour. People with ADHD can seem restless, may have trouble concentrating and may act on impulse. Eva's father also had a history of self-harming. CAMHS records from 2015 note he had been assessed by CAMHS over 4 years, but the outcomes of the assessments were not clear on either CAMHS or other agency records.

Eva's mother is recorded as attending six different schools. She was known to Croydon Children's services as a child for a short period between March and May 2000, and again in May 2017 when she was involved in an incident where a male was assaulted.

Prior to her relationship with Eva's father, she came to the attention of the police, twice for drug searches, resulting in no further action and once where she was with her brother when he was involved in a fight.

Period from May 2022 to February 2023– Antenatal period to point of discharge from midwifery care post birth of baby Eva

Eva's mother booked for antenatal care in the Princess Royal University Hospital, a hospital outside of Croydon. In exploring the reason for an out of area hospital it became clear that the specific location within the borough where Eva's mother's home was, meant that the chosen hospital was as accessible as the one situated in the borough. Professionals from the Princess Royal University Hospital stated those living in that area frequently chose to access services at this hospital, which reinforces the importance of having effective cross borough communication pathways.

Eva's mothers antenatal care was as the result of a self-referral, which is common practice nationally. At booking, safeguarding questions were asked with no concerns arising. Routine enquiry regarding domestic abuse took place twice and there were no disclosures. All appointments were attended between July 2022 and January 2023 except two in one week, which was reported to be due to illness. Following the two missed appointments the expected appointments were attended. In February 2023 Eva's father was noted to be verbally aggressive with staff due to a change in the appointment plan. It was documented that Eva's mother was unable to talk as she was interrupted by her partner and was "not allowed to speak". There is no documented follow up and no record of routine enquiry following this. The hospital safeguarding team were not consulted. This was a missed opportunity. Eva's mother had self-referred; the hospital would not routinely have background history from the GP; There was a need to be more curious. Given the presentation professionals should have communicated with the parents GPs to share and request appropriate information.

In February 2023 Baby Eva was born at Princess Royal University Hospital by emergency caesarean section. Due to the mode of delivery and Eva requiring antibiotic therapy the post-natal stay in hospital was for a number of days. During this time, Eva received transitional care. This approach had been introduced approximately a year ago for children with additional care needs, such as antibiotic therapy. Adopting this approach, meant rather than separating babies from their parents by transferring them to special care units, they received care from specially trained professionals on the ward with their parents. This is a positive approach in promoting attachment. On the day following Eva's birth her father was noted to feed her while she was lying flat. Advice was given not to do this, and the risk of choking was explained. On the same occasion the parents requested paracetamol as they reported Eva to be unsettled. Professionals noted her to be asleep and settled. Again, there is no evidence of this escalating picture of concern being followed up.

By the fourth day following delivery it had been noted over a number of days and by a number of professionals that Eva's father was abusive to professionals and professionally "intimidating". Again, there is no documented follow up and no record of routine enquiry following this. The hospital safeguarding team were not consulted.

Croydon maternity services and Croydon health visiting services were sent and received the maternity discharge summary from Princess Royal University Hospital. No safeguarding concerns were highlighted on the discharge summary. Given the concerns around Eva's fathers presentation this was a missed opportunity.

Following discharge from the hospital, care was transferred to the Croydon midwifery team who completed a telephone assessment of Eva and her mother, where no concerns were identified.

In March 2023 Eva's mother reported having good support from her partner and mother and was discharged from midwifery care to the care of the health visitor and GP.

Period from March 2023 – June 2023, the period from health visitor undertaking new birth visit to the date the Interim Care Order was agreed following Eva's admission to hospital.

In March 2023 the health visitor undertook the new birth visit and the health needs assessment was completed as part of the visit. The assessment resulted in the family receiving universal health visiting service, as there were no safeguarding concerns raised.

At the end of March 2023 in line with the universal service, a six-week follow-up health visitor visit was arranged. The father was seen at the front door and stated they were all having a sleep. The health visitor advised she would telephone later, which happened later that day. The 6-8 week review visit was rearranged.

At the beginning of April, the London ambulance service had been called with a report that Eva had woken from sleep gasping and gulping / choking, but since appears to be improving. The outcome was for Eva to be taken to a treatment centre within four hours. Eva was presented at the hospital by her parents. The presenting concerns are recorded as noisy breathing, which was thought to be due to a cold with a congested nose. There appears to be a difference in the concerns recorded by the ambulance service and the hospital.

In the middle of April, Eva was seen by the GP for a routine baby check and by a practice nurse for immunisations and no concerns were noted. Both parents were present. Eva's mother raised concerns about "vertical lines on Eva's skin that come and go". The GP requested the mother take photos to share with the GP. This didn't happen. At this time Eva's mother saw the GP for her post-natal check. She reported her partner to be supportive, that she was coping well with parenting. Routine enquiry re domestic abuse was undertaken and assessment made using the Edinburgh post-natal depression score. No concerns were identified or reported.

Towards the end of April 2023, the health visitor 6-8 week review took place. There were no safeguarding concerns raised at the visit.

At the end of April, the GP saw Eva with a shoulder “concern”. Eva’s mother thought this may have been the result of birth trauma. Eva’s parents were asked to take her to the hospital for an x-ray but there is no record she was taken.

In May 2023 Eva was seen at the GP practice for her second immunisations. The same month Eva was taken to the Accident and Emergency department with a scratch and redness on her right ear. It was noted that the parents did not wait to be seen and left hospital without Eva being seen by the doctor. The GP was informed.

In June 2023 an ambulance was called as Eva was reported to be unable to lift her right arm. An ambulance was dispatched but was then cancelled by the parents as they stated they were making their own way to hospital.

Following Eva’s arrival at the hospital an examination took place, and an x-ray was performed, which identified a fracture to her right upper arm. There was agreement that the injury was not consistent with a self-inflicted injury. Parents were advised that safeguarding procedures would be initiated as a result.

A full skeletal survey was performed which identified multiple fractures of different ages.

Blood tests and a CT scan of the head were initiated together with an ophthalmological review. No other possible cause for the injuries were established. Health professionals concluded that the multiple injuries had been caused by a third party and were non-accidental injuries (NAI).

A second opinion was sought from a specialist health professional at a children’s hospital, who has nationally recognised expertise in such injuries. A subsequent report from this expert found no evidence to suggest any injuries were caused at birth and the expert deferred to the original doctors view that they were NAI.

A strategy meeting took place and baby Eva, when fit for discharge, was discharged to the care of a foster carer.

9. Thematic analysis of Eva's story – Summary and Findings

The findings are presented below aligned to the key lines of enquiry.

Theme 1	Assessment of the impact of previous learning.
Theme 2	The impact of systems on the quality and response to information sharing.
Theme 3	Responding to information about fathers and other children.

Theme 1: Assessment of the impact of previous learning

How was this issue relevant to the review?

In 2020 Croydon Safeguarding Children Partnership commissioned, jointly with another London borough, a Child Safeguarding Practice Review (CSPR) following a rapid review where the child, Cora was found to have suffered multiple serious injuries including fractures, both new at the time she was taken to hospital and older.

The CSPR relating to Cora identified learning relating to the extent to which health services recognised and responded to evidence of non-accidental injuries and the effectiveness of the treatment pathways in A&E in ensuring that the most appropriate professional responded to safeguarding concerns.

There were a number of factors in the rapid review undertaken in respect of Eva, including information known about her parents, that aligned to those identified in the CSPR for Cora. Specifically, questions relating to the *effectiveness of information sharing across agencies and across boroughs to inform timely assessments and decisions.*

It was therefore important to assess whether the learning that emerged from the LCSPR Cora has resulted in practice improvements as demonstrated in the care provided to Eva.

An analysis of the findings

The LCSPR Cora found a systemic failure to respond to the safeguarding risks and when safeguarding concerns were identified no rigorous process was followed.

There are similar failures identified in Baby Eva, particularly in the antenatal and early postnatal period. However, at the stage that Eva presented at the hospital unable to lift her arm, there is evidence of a robust process being followed that aligns with best practice (RCPCH 2020, London Safeguarding Children Partnership 2022). The process followed in the case of Eva resulted in her being safeguarded post injury.

However, in light of this review there is the need for ongoing assurance that the learning is from both reviews is having an impact on practice at an earlier stage.

Following Eva's arrival there was a thorough assessment, recognition of the potential for the presenting problem to be the result of a non-accidental injury and this resulted in the safeguarding process being initiated quickly and efficiently. There was evidence of good multiagency communication. Within 48 hours a strategy meeting was held. The health professionals ensured appropriate medical assessments were completed in a timely way, providing the evidence base to secure the necessary court orders to safeguard Eva.

Although information sharing at the time of Eva's admission was good and resulted in a planned safeguarding process, prior to the admission there were occasions where information sharing worked less well. This will be considered below under themes 2 and 3.

Why is it important for children? - What can we learn from local and national research?

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents.

Eva presented to the hospital with serious injuries. It is important to note that had a rigorous safeguarding response not been followed the consequences for Eva could have been catastrophic.

The National Child Safeguarding Practice Review Panels' annual report 2018-19 noted:

"We have been profoundly disturbed by the number of serious incidents involving the non-accidental injury of babies, often resulting in their death or life-long impairment."

Evidence of good practice

There was evidence of good multiagency safeguarding practice when baby Eva and her parents presented at the local hospital. The rapid review agreed that the learning from this example of good practice would be shared.

Theme 2: The impact of systems on the quality and response to information sharing.

How was this issue relevant to the review?

The rapid review undertaken for Eva raised a number of concerns around information systems impacting upon assessment practice and therefore the safeguarding of Eva.

In requesting information for the rapid review, CAMHS, initially could not locate records to confirm they had provided services for Eva's father.

During the rapid review it was evident that the recording systems across health organisations were different and not accessible to other health organisations. Additionally, there was a systems issue, in that information held on the historical health recording system, EPEX, was not readily available to all staff. Alerts from EPEX were reportedly transferred to the current system, however in this case, it did not highlight known concerns, which suggests a potential system issue.

When Eva's mother booked antenatally she self-referred. As a result, there is no background information from GPs. Without common IT systems this exacerbates risk. It is not existing practice to request this. Information to inform assessment therefore relies on self-reporting. When concerns present it is important that information recorded is triangulated, this is particularly important when information is held on out of borough information systems, where there is not shared access.

Eva was born at an out of area hospital. This posed challenges in that their systems were not accessible to Croydon Health professionals.

When the health visitor undertook the new birth visit the address on the discharge summary provided by the hospital where Eva was born was not the address Eva and her mother returned to following hospital discharge.

It was also identified that the police protocol, resulted in the interrogation of their records for strategy meetings, only covering a defined period of five years. This meant significant information outside this period, which existed in the case of Eva's parents, would not be considered as part of the assessment of risk. There is a need to ensure that where a search covers only a defined period of time, this is clearly articulated and should multi-agency information suggest there may be relevant information outside this period, a more extensive interrogation takes place.

Information sharing is a basic tenet in Working Together 2023. Where there are constraints in systems and processes for accessing and sharing information, this increases the risks to children.

An analysis of the findings

Systems and processes refer to the technological landscape that practitioners rely on to record and have an overview of information that contributes to the assessment and planning of the care for children and their families. Often, as was the case for Eva, systems do not "speak to each other", making "manual" approaches to information sharing an essential component of safeguarding practice. There is often no way for any one practitioner to know who holds information on a child or their family members. In providing services for Eva there was also information held on a system no longer in use.

Given the challenges posed by information systems, which are greater when an individual accesses cross borough care through self-referral, systems should be reviewed to ensure available information is sought and triangulated. This is particularly relevant in this case, given the extensive history related to Eva's father.

Following Eva and her mother's discharge from hospital postnatally, the new birth was undertaken face to face. Given the workforce pressures and the continued practice post covid of virtual appointments, adopted in many areas, this was good practice. When the health visitor visited the address on the hospital discharge and found it was the incorrect address, she was persistent in her attempt to locate Eva and her mother to undertake the new birth visit.

Prior to the admission leading to the review, Eva had been taken to the GP with a shoulder concern. Given her age this is an unusual presentation, but it appears that this presentation was not considered within the context of safeguarding. There was no follow up in terms of checking that the advice to attend the hospital had been followed. In discussion with the GP it is apparent that the current electronic record system does not flag up if someone has not attended for an X-ray. This was a missed opportunity to safeguard Eva. The GP practice has reflected upon the learning and is establishing a system for all children under one year to be flagged and followed up if sent for further tests/investigations. It would be good practice to promote the approach developed by this GP practice following learning from the review to all Croydon practices.

Professionals providing services to Eva faced significant pressures in terms of workforce. recruitment and retention challenges are a national issue but are exacerbated within Croydon as a result of its proximity to other London boroughs, where employees receive higher cost of living enhancements to their salary. Professionals spoken to, highlighted the time-consuming nature of searching for information, alongside caseloads with high numbers of children/families.

Professionals spoken to raised the fact that staff turnover and the need to "start again" when familiarising oneself with family background/context impacts upon assessment and care.

It is important to acknowledge these real pressures on staff but, as a system, there is a need to ensure safeguarding practice is not adversely impacted.

The experience of Eva meant that the lack of appropriate and timely sharing of information, particularly about her father, her half-sibling, history of domestic violence, parental mental health concerns, parental history of aggression, substance use and criminality meant that the nature of risk to her was not fully recognised or acted upon at the stage of prevention/early help. This was exacerbated by the fact that although antenatal self-referral is now common practice, relevant history is not accessible due to different IT systems across health and is not sought from GPs. Current systems do not allow triangulation of information shared.

Eva's mother's antenatal care and birth took place in an out of area hospital. The information system used at that time was not accessible to Croydon health professionals. There was a reliance on manual hand over of relevant information. There was information known to the hospital where Eva was born that related to aggression displayed by the father of Eva, just prior to her birth and in the post-natal period, which was not communicated to Croydon professionals. This information was also not discussed with their own safeguarding team, who were reported to have a "real presence" on the wards.

In discussing this with members of the maternity team it was evident that the degree of aggression was concerning. Professionals described it as persistent; on one occasion, taking place continuously throughout a whole day. The behaviour was also perceived (by some staff spoken to as part of this review), to be racially motivated. Staff spoke about how the behaviour was intimidating and resulted in one member of staff becoming distressed and tearful. Managers and consultants were reported as having to visit the parents to address the concerns. Professionals also spoke about how the father's aggression was aimed towards Eva's mother, when she spoke about her intention to feed Eva.

Professionals confirmed that, if they were concerned, the usual practice would be to discuss with the safeguarding team and telephone the community midwife and health visitor, in addition to providing the information in the written transfer documentation. However, professionals also raised the fact that the transition to parenthood is potentially an overwhelming time for parents as it leads to high levels of physical and emotional stress, sleep deprivation and changes in family relationships. Midwives reported that in their experience, parents presenting aggressively was not uncommon and therefore a judgement needs to be made as to whether it is a reaction to the stress of transitioning to parenthood as against a safeguarding concern. Professionals expressed the view that had they been aware of the father's background, the father's presentation resulting in staff "feeling intimidated" would have resulted in safeguarding concerns being raised. There are clear examples of Eva's fathers concerning presentation on a number of occasions and what appears to be the "normalising" of aggressive behaviour by professionals in the antenatal and early postnatal period. The "normalising" of aggression has been highlighted in other reviews and may be a response to vicarious trauma.

Professionals were clear that during the hospital stay, they never witnessed aggression towards Eva. However, if staff felt intimidated, the lived experience of Eva and the impact of being cared for in this environment should have been the focus of their assessment and response.

The failure to share information with safeguarding professionals and with Croydon professionals who would be providing care in the community would have impacted upon the ongoing assessment of need and risk. In talking to other professionals and their managers, it was clear that had the information been known, the service offer to Eva would have been above the level of universal.

In conversation with the hospital maternity professionals, they spoke about a new information system that has very recently been adopted that allows a range of health professionals to access information. This will enhance the quality of information sharing for residents within that borough but for those living out of their area as were Eva and her family, the system will not be accessible and there needs to be adherence to the existing process of ensuring all relevant information is shared.

Clearly systems that are not accessible to all professionals raise real challenges and the need for a consistent approach to compensate is key. On the occasions where this did not happen, it resulted in professionals practising in isolation on the basis of known but incomplete information.

Why is it important for children - What can we learn from local and national research?

Poor information sharing between the agencies that work with children and families is frequently cited as a systems weakness in reviews following the death of or serious injury to a child.

In 2022, the National Child Safeguarding Practice Review Panel report 'Child Protection in England,' along with the Independent Review into Children's Social Care, reported how the problems with sharing, seeking and using information about a child and a family persist and strongly emphasised the need for this to be addressed.

There continues to be national work that is ongoing that recognises the need to develop technology as a means to improve information sharing (DfE 2023), however this does not offer any immediate solution.

Although there is a need to acknowledge the barriers to sharing information, more needs to be done to address the "stubborn challenge" and facilitate better information sharing between professionals to ensure children like Eva are better safeguarded.

Nationally there are examples of innovative practice that have been implemented to improve information sharing, despite systems barriers. One such example that is relevant to the experience of Eva is the work undertaken in Northumberland cited in the report published by NCASP (2022).

Northumberland's work, the SIRS (Sharing Information Regarding Safeguarding) project is an approach developed by health partners, designed to improve information sharing about fathers and male partners:

https://proceduresonline.com/trixcms1/media/12680/annual-report-2021-22-final.pdf

This approach ensures that following the booking appointment with maternity services, the parent/s are informed by letter that information will be sought from both parents' GPs, this is repeated at future appointments. While it was designed to improve information sharing about fathers and male partners, it evidences that by using innovative approaches current barriers to information sharing can be overcome.

Recommendations

Recommendation 1:

The CSCP should seek assurance that in light of this review, partner agencies have reviewed their systems and practice, learning from what other areas have implemented to overcome systems barriers to ensure that appropriate information is sought and shared. Areas for partners to review should include information gathering relating to fathers or male partners to inform assessment and risk assessment, with consideration given to the work undertaken in Northumberland.

Recommendation 2:

The CSCP to share the findings of this review with the out of area hospital where Eva's mother attended antenatally and gave birth, to enable them to consider what action they need to take in response to the identified factors that impacted upon the safeguarding of Eva, including insufficient exploration of the father's history, the potential gaps in assessment following self-referral, cross boundary information sharing and the "normalisation" of parental/carer aggression resulting in safeguarding risks not being identified and shared.

Recommendation 3:

The CSCP to seek assurance that the "normalisation" of parental/carer aggression which featured in this review is not happening routinely in Croydon agencies and there are appropriate systems in place to support professionals who may be at risk of vicarious trauma.

Theme 3: Responding to information about fathers and other children

How was this issue relevant to the review?

In common with other reviews, there were gaps in the quality of information sought and shared by agencies, specific to Eva's father history that was known to some professionals but not others. A summary of the relevant background history is detailed in theme 2 and includes his role as a father to his first child, areas of risk, including the potential impact of him being care experienced and the history of domestic abuse.

There were also gaps in information sharing regarding the concerns re father's feeding practice and aggression immediately prior to and immediately post-delivery.

An analysis of the findings

Information that was known about Eva's father was comprehensive across the agencies, but key professionals did not have the complete picture. The father's name was documented at the antenatal booking appointment in August 2022 and shared with the mothers GP.

In discussing antenatal history taking with professionals, they confirmed they would ask basic details related to the father but would not explore the father's history in any depth.

Interestingly Eva's father was visible and seen with Eva's mother and with Eva on a number of occasions, which gave an opportunity to include him in the assessment. However, despite being visible he was not a significant focus within assessment practice. NSPCC (2022) in their analysis of serious case reviews found that fathers sometimes go 'unseen' by services involved with children due to:

- a lack of professional engagement and curiosity.
- an over-focus on the quality of care children receives from their mothers.
- inadequate information sharing between services.

In this review, although parents were registered with the same GP when the rapid review took place, in conversation with the GP it became apparent that Eva's father had only registered at the practice a month prior to the rapid review and had been registered with three different practices in the preceding four years. Eva's mother had been registered with a practice different to her partner's during the antenatal period and she and Eva only registered at the same practice as Eva's father when Eva was 4-5 weeks of age.

In discussion with the GP at the time, when the records transferred from the previous practice, there was significant background held within the records, but the significant history was not immediately apparent as the expected codes to flag this were not applied. In identifying this during this review the current GP planned to address this by reading the records and applying the relevant codes.

The reasons for the appropriate codes not being in place is not clear and given the different practices Eva's father had been registered at, it is not clear which practice would have been responsible for applying them.

Within GP practices, it is expected that a coding system is utilised. The purpose of such a system is to ensure significant information is immediately obvious on a patient's notes to all health practitioners. The documentation of safeguarding information on a patient's record is as important as the coding and documentation of any other significant medical issue such as cancer, diabetes, mental health or learning disability.

Although the GP records held information on Eva's father, there is no agreed process to ensure information on fathers is reviewed and relevant information shared, to inform assessment. If any safeguarding information relevant to a child or young person comes to light when caring for a third party (including parent or carer) the GP would be expected to record and flag this appropriately in the child or young person's notes and to take the appropriate safeguarding actions. This is made more challenging when parents are registered with different practices as was the case for Eva's parents in the antenatal period.

Father's own experiences from childhood into adulthood, and the circumstances regarding his having no contact with his own child due to high and extremely concerning levels of domestic abuse against a previous partner, was significant in assessing both parenting support needs and risk.

The National Child Safeguarding Practice Review Panel (2021) undertook a review of non-accidental injury in children under one year of age and identified a range of

common presenting parental features including domestic abuse, parental mental health, including history of anxiety and depression, ADHD and anger management, criminal conviction history, history of involvement with probation and experience as a care leaver, all of these were features known about Eva's father.

Relationship-based practice is crucial in working with parents who have experienced trauma or instability or abuse in their childhood. This approach needs to be applied to fathers as well as mothers, as those who have experienced trauma often display difficulties in how they can respond to and understand the needs of their own children; this can manifest itself in many ways including putting their own needs before that of their children, having unrealistic expectations for a child's developmental stage and inability to understand and respond to a baby's crying. A relationship-based approach supports assessment practice.

Concerns regarding her father feeding Eva whilst lying flat were identified by the hospital maternity professionals and were not shared. Although it cannot be evidenced, there is a possibility the choking episode resulting in the ambulance being called when Eva was at home, in the care of her parents, may have been the result of poor feeding practice.

In considering the range of information available for this review, a number of factors impacted upon effective risk assessment, the lack of appropriate use of coding to identify significant present and historical factors relating to Eva's father, lack of robust assessment practice, in particular relating to fathers, the lack of identifying concerns as safeguarding risks and therefore the sharing of information to inform future assessment of need and risk.

Why is it important for children - What can we learn from local and national research?

To ensure that as a system, children are both protected and supported to meet their full potential, practitioners need to proactively assess and engage with all significant adults in a child's life, understanding that some may be a protective factor whereas some may pose risks. It is widely recognised as problematic that there are generally low levels of engagement by professionals with significant males in the life of children with relatively little focus given to what works in engaging men.

The transition to fatherhood can have a significant impact upon men's emotional health and well-being. Experiences of abuse and neglect in childhood correlate with increased rates of depression, and self-harm in adulthood. It is likely that the mental health of fathers who have spent time in care as children due to maltreatment will be more severely affected by the move to fatherhood (Dandy et al 2020).

LCSPR Ben (Croydon LCSP 2022) identified some aligned themes including the fact that the needs of infants and toddlers can be missed when there is no engagement with a parent. It also raised practice questions about how to engage parents where there are concerns about alleged domestic abuse and the need for assertive enquiry and analysis about men who are known to have a violent history and who form new relationships.

In order that children such as Eva are effectively safeguarded it is imperative that all known information that either lowers or raises concerns is considered and understood, forming part of a balanced risk assessment. This requires communication and effective sharing of information between professionals involved or with those who have knowledge of, as well as conversations with, fathers. This can support good practice, ensure the appropriate level of help and support is agreed and help professionals navigate difficult areas thereby avoiding over optimism.

Recommendations:

See recommendation 1

Recommendation 4.

CSCP to seek assurance from the ICB that the reason for coding relating to the father's history was not evident in GP records is understood. Once the reason is established the CSCP should consider whether there is a need for the ICB to undertake an assessment to gain assurance across the borough that GP practices are applying a system of coding that facilitates the immediate identification and sharing of safeguarding concerns for different health practitioners working within the practice, staff who may work in multiple practices, and for when patients transfer surgeries.

10. Summary of recommendations

The recommendations arising from this review are detailed below, with details of the themes with which they align.

	Recommendation	Themes that the recommendation emanates from
1	The CSCP should seek assurance that in light of this review, partner agencies have reviewed their systems and practice, learning from what other areas, have implemented to overcome systems barriers to ensure that appropriate information is sought and shared. Areas for partners to review should include information gathering relating to fathers or male partners to inform assessment and risk assessment, with consideration given to the work undertaken in Northumberland.	Theme 2: The impact of systems on the quality and response to information sharing. Theme 3: Responding to information about fathers and other children
2	The CSCP to share the findings of this review with the out of area hospital where Eva's mother attended antenatally and gave birth, to enable them to consider what action they need to take in response to the identified factors that impacted upon the safeguarding of Eva, including insufficient exploration of the father's history, the potential gaps in assessment following self- referral, cross boundary information sharing and the "normalisation" of parental/carer aggression resulting in safeguarding risks not being identified and shared.	Theme 2: The impact of systems on the quality and response to information sharing.
3	The CSCP to seek assurance that the "normalisation" of parental/carer aggression which featured in this review is not a happening in Croydon agencies and there are appropriate systems in place to support professionals who may be at risk of vicarious trauma.	Theme 2: The impact of systems on the quality and response to information sharing
4	CSCP to seek assurance from the ICB that the reason for coding relating to the father's history was not evident in GP records is understood. Once the reason is established the CSCP should consider whether there is a need for the ICB to undertake an assessment to gain assurance across the borough that GP practices are applying a system of coding that facilitates the immediate identification and sharing of safeguarding concerns for different health practitioners working within the practice, staff who may work in multiple practices, and for when patients transfer surgeries.	Theme 3: Responding to information about fathers and other children

11. Closing Statement

This review has shown the importance of professional practice focusing upon the learning from previous reviews and research that identifies the vulnerability of non-mobile babies.

The review has highlighted the importance of developing creative approaches to information sharing and professional curiosity when systems that don't talk to each other present barriers. This is of even greater importance when other factors impact upon assessment, including cross-borough care and different family members being registered with different health providers, in this case GPs.

The importance is highlighted of viewing male parents as equally important as the female parent in the lives of children and therefore the need to include them in a meaningful way in assessment practice, particularly when their own history may require targeted approaches to enable them to transition to parenthood.

In undertaking this review, it is important to acknowledge the impact that the experience of Baby Eva's injuries has had on those that knew her. The impact on professionals was evident and cannot be underestimated. All professionals involved in this review held open, honest, and difficult conversations. This review has highlighted examples of excellent practice across the Croydon partnership as well as areas for development. Professionals engaged fully with the review, demonstrating personal reflection and willingness to change their practice. It has been through the positive engagement from agencies with this review process, which has enabled the identification of the learning.

It is recognised that actions have already been taken in relation to some of the individual agencies which identified learning as part of the rapid review and that changes have been made. In addition, during discussions with professionals, as new learning emerged, further actions were agreed to be taken forward in a timely way. The recommendations made are to support systems learning.

12. References

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