Child Safeguarding Practice Review

“Jamie”

Commissioned by: Devon and Plymouth Safeguarding Children Partnerships as a joint review

Author: Dr Joanne Nicholl, Designated Doctor Safeguarding Children, NHS Somerset

Contents

Executive summary

1.1 This review concerns a little girl, Jamie who sustained a life threatening and life changing head injury in July 2024 whilst in the care of her adoptive parents. Jamie was 20 months old at the time and had been removed from her birth parents 12 months previously due to their alcohol and substance misuse and domestic abuse.

1.2 The review was commissioned and written on the assumption that the injury was non-accidental, however the subsequent Finding of Fact Hearing and Police investigation concluded that there was insufficient evidence of a non-accidental injury and so the police investigation resulted in no criminal charges. Similarly, the safeguarding investigations were concluded by the Police and Local Authority and full care of Jamie was passed back to her adoptive parents. Never-the-less in other similar circumstances the injury could have been non-accidental and so the learning from this review remains of value as it has identified significant gaps and opportunities for improvement in the safeguarding of children, particularly those in care. The narrative provides background information showing why these actions are required.

1.3 The scope of enquiry concerns the time from the decision to remove Jamie from her birth parents on 17th July 2023 to the date of her injury, a year later, on 14th July 2024

1.4 Jamie is described as a smiley, curious and active child, loving adult company, playing with other children, dancing to music and was very fast on her feet when she started walking. She is white British, female and had no disability at the time of her adoption. Her adoptive parents were a white British, female couple. Neither had any known disability and both were working in the health system.

1.5 Jamie is not able to tell us what happened, but her story is told in such a way that her voice is heard by those reading this report. The author was not able to interview her parents directly due to the active police investigation, however they did take part by answering an agreed series of questions put to them via the police.

1.6 The overarching themes of learning from this review are about the lack of rigour of statutory processes and staff not making use of supervision. There was an over reliance on professional's feelings about the parents rather than statutory evidence.

1.7 There was a tendency for "group think" and potential over optimism about the parents and at no point did anyone question this positive view despite two incidents where Jamies had bruising or marks that have significant association with non-accidental injury.

1.8 The planned closure of the case at the point Jamie was adopted functioned as a barrier preventing SWs "thinking the unthinkable" and this was not questioned by managers.

1.9 Neither of the two significant incidents that could have been non-accidental were discussed in supervision, and this was a missed opportunity to potentially safeguard Jamie. This is a critical area for the system to address.

1.10 Adoption Matching Panel meetings took place despite missing or poor-quality information and without the right people in the room. These are significant decision-making meetings for a child's long-term future and deserve to be informed by high quality statutory evidence and multiagency professional opinion.

1.11 There was an overreliance on ad hoc visits by Children's Social Care to inform decision makers about her world, rather than high quality unannounced home visits with the whole family that included a review of her bedroom which are a statutory requirement.

2. Jamie's Story

2.1 My name is Jamie, and I am 2 years old. When I was 20 months old, my Mum Alex called an ambulance because I was having a fit. She said that I had fallen over in the kitchen and banged my head on the floor. I was taken to hospital and had emergency surgery because I had badly hurt my head and otherwise, I would have died. I have been in hospital for a long time. The doctors and nurses who are looking after me still don't know how much I will be able to recover but say that I am going to need a lot of help as there will be many things I will not be able to do for myself as I grow up.

2.2 Once I got to hospital, the team became worried that my injuries were so severe that they didn't think they had been caused by just falling over and banging my head. I had a scan that showed a crack in my skull [fracture of the left parietal bone that had extended and split the sagittal suture]. Just underneath the fracture was a large blood clot that was squashing my brain [acute subdural haematoma from the sagittal sinus]. An eye specialist [ophthalmologist] saw me and found that I had a lot of bleeding at the back of my eyes [retinal haemorrhages] and said this is not something they usually see in a child who has fallen over but are more common when someone has been hit or in a road accident [high impact injury]. Because of this the police thought that someone might have hurt me and arrested my Mum Alex.

2.3 Alex was not my birth mother but adopted me with my other Mum Lucy. When I was born my birth parents were struggling with drug and alcohol use and so at 4 weeks of age I was taken into care [via an Emergency Protection Order]. I went with my parents into a Child and Parent Placement and for a while things were better, so I was allowed to go home with them. But after one week at home my Mum and Dad had a bad argument that was frightening and could have resulted in me getting hurt, so I was moved into a foster home. On 17 July 2023 it was decided that my parents would not be

able to look after me and that I should be adopted. Although I was only little, this was a very scary and unsettling time.

2.4 Three days later Alex and Lucy came to see me, and I started to spend some time with them. Two weeks later, I moved in with them full time and they became my two new Mums at the end of August, when a Placement Order was granted. In April 2024, an adoption order was made, and they officially became my parents.

2.5 Because my birth parents used drugs, drank too much, had big scary arguments and were not able to look after me, this could have made it difficult for me to trust adults, feel safe and develop properly, so my new Mums should have had lots of support to help them understand my needs and look after me. Professionals are concerned that visits did not happen as frequently as they should have done and often, they were video calls and not actual visits so it would have been difficult to really know how we were all getting on. There were a few times when I was noticed to have bruising that might have been due to someone hurting me, but the people asking about it accepted my mum's explanation even though the type of bruising I had [on the pinna of the right ear and a subconjunctival haemorrhage in the eye] doesn't happen very often by accident. They might have been less worried because my Mum's both worked in the health system and so perhaps people trusted them when they should have been a bit more curious. The adoption process involved lots of checks on Alex and Lucy so people might have felt they could rely on this and maybe did not make up their own minds. Or it might have been because they were both women and so people thought I would be safe in their care.

2.6 The Police and Children's Social Care looked into what happened to me and decided that my injury was an accident so I can now stay and grow up with my two Mums, who love me very much and have been by my side all the time I have been in hospital. But they felt that there were still times when things could have been done better and in a similar situation it might have been that someone hurt me. This review is going to look in more detail about what happened and if there were things that went wrong or could have been done better, professionals will use what they learn to try to stop another child being hurt. One day I might read this report and so the author wants me to know that everyone heard my voice.

3. The Early Adoption Process

3.1 Both the Team Manager and the Operations manager at Adopt South West (ASW) were interviewed as part of this review. The Team Manager had been involved with Lucy and Alex from day one. She was involved through stage 1 and 2 of the adoption process and is currently still supporting them so has provided good continuity for the family. The Operations manager was not involved with the family until Jamie's injury but was able to

share information about the adoption process. Although the early adoption process is outside the period of this review, information has been included where it is relevant to the understanding of agencies assurances about the suitability of Alex and Lucy as parents.

3.2 Alex and Lucy approached ASW in March 2022 about being assessed to become adoptive parents. Stage 1 of the adoption process commenced on 26.09.22 and included personal references, a medical assessment, training and directed learning as required as part of the adoption regulations. This was completed on 10/01/23 and they were allocated to an assessment social worker (SW) (a different person to the Team Manager) on 13/01/23. There were no concerns raised through this process although Lucy did comment that when they first met Alex was not good at sharing her worries and tended to bottle things up. However, they both felt that she was now more open, and this was also the ASW SW's view. The couple were noted to have a good support network.

3.3 The couple attended the adoption approval panel on 19/04/23, expressing a desire to adopt a child between 0 and 2 years. There was a unanimous positive recommendation for approval. The decision to approve the couple as adopters under the Early Permanence scheme was made by ASW's decision maker on 25/04/23. Early Permanence is also called Fostering for Adoption. It is used for babies and children who are in care where the plan is likely to be adoption, but who still have a chance of being reunited with their birth family. There are benefits for the child of this approach; it avoids the trauma of multiple moves; helps the child develop a sense of belonging and security and allows them to bond with their potential adoptive parents sooner. For parents, it allows them to be involved with their child at an earlier stage; there will often be contact with the birth parents, so puts them in an advantageous position to understand their child's background and struggles. However, it does require the parents to be extremely child-centred and have the emotional resilience to accept that the court might decide to return the child to their birth parents. Once the decision is made to approve parents as foster carers under this scheme, it happens very quickly. Parents need to understand this, and their employers need to be supportive of them suddenly going on adoption leave. { Fostering for adoption protects a child's journey in the care system}

3.4 Lucy and Alex were asked what they thought about their preparation to Adopt and replied that they felt, "*the information provided was appropriate, informative and useful*." Also, "The *adoption process was rigorous and very in depth. [It] looked in depth at our personal upbringings, our morals and principles, employment history, living history, financial history, lifestyle choices, life experiences, health history, experience with children including references on this, family backgrounds and previous relationships. We felt fully prepared and supported to become parents. We have a home, good careers, good friends and family already to support ourselves and daughter. All who fully support us now through this emotional and extensive hospital journey.*" They did not give any specific feedback on the Foster to Adopt pathway.

3.5 Jamie's profile went live on Link Maker on 25/5/23, so Lucy and Alex would have been able to see it from this point. Jamie's SW was sent reports on three prospective adopters and

there was a plan agreed to proceed with a home visit for Lucy and Alex. A Permanency Planning Meeting took place on 12/06/23. Three days later the SW met Alex and Lucy at their home. She found them welcoming and interested in Jamie. They had put a lot of thought into the foster to adopt process and about who would be the primary carer. They had a good support network and were very active "outdoorsy" people which fitted well with having an active child. They had a "lovely home," and the SW commented that she "got a positive sense about them" that she "didn't get very often." They had experience of looking after children through their nephews and nieces. They were keen that Jamie would know her history, to meet with her birth parents and seemed to ask all the right questions. They felt like an excellent match for Jamie.

3.6 On 17/06/23 Alex and Lucy were approved as temporary foster carers. A month later, on 17/7/23 the Agency Decision Maker approved the plan for adoption for Jamie and on the 19/07/23 there was a transition planning meeting. The following day the couple met Jamie for the first time. This would clearly have been an emotional time for Alex and Lucy, but they and their SW felt they were prepared and supported to become parents. The usual route to becoming a Foster to Adopt carer had been followed with the appropriate checks and assessments all completed and giving a positive recommendation.

3.7 Jamie had received a Child in Care Review Health Assessment (RHA) shortly before she met Alex and Lucy. At this time, she was 7 months old, was a healthy weight, "a delightful baby with an infectious laugh", who enjoyed cuddles and had bonded well with her foster carer. The only medical issue identified was that she sometimes has loose stools, about which her carer was advised to speak to the Health Visitor (HV).

4. Transition of Jamie into Alex and Lucy's Care

4.1 The transition between Jamie's former foster carer and her moving in fulltime with Alex and Lucy took place between 20/07/23 and 09/08/23. During this time there was an expectation that Jamie's SW should have visited on the first day, midway and on the placement day. There was a midway review of the transition on 02/08/23 where there was positive feedback from Alex and Lucy, ASW and Jamie's SW and an agreement to continue with the plan for Jamie. This transition plan is not on the Devon Children's Social Care (CSC) system but was held within emails between the ASW and CSC SWs. Transition plans should be uploaded to the child's SW record. Jamie's SW recalls having no concerns about Jamie. She felt that the parents were always open and safety conscious. She described them as "helicopter parents" always hovering over Jamie to make sure all was OK. She felt that despite being health care workers, they knew their limitations and were regularly seeking advice. This SW was on leave between 24/7/23 and 4/8/23 and she arranged for a colleague and her line manager to cover the statutory reviews but there does not appear to be any notes relating to reviews in her absence, so it is unclear exactly what took place.

4.2 On 09/08/23 Jamie moved in with Alex and Lucy full time and Jamie's SW visited the home and saw the three of them together. Observations were positive and the Placement planning meeting took place the same day. This was chaired by Jamie's SW. It is recommended that these meetings are chaired by a SW Manager who may be able to provide more independent curiosity and challenge. It appears that despite the recommendations it is not common for a manager to be available for these meetings. Prioritising Placement meetings for SW managers should be considered.

4.3 On 15/08/23 the public health nursing team in Plymouth were notified that Jamie had been transferred into their area. The Devon HV sent Plymouth an email with all the background information on Jamie but for some reason the Plymouth HVs never saw this and it is not on Jamie's records. There is a clear process for transferring information but on this occasion, it appears to have failed. It would be worth reviewing this process to ensure it is robust. The following day Devon children in care team were formally notified that Jamie had been placed in Plymouth with prospective adopters and a copy of the recent RHA was sent. Plymouth CSC was not involved with Jamie until her injury on 14/07/24. Although the HV handover complied with current recommended timescales, it may have been helpful for these notifications to have been made on the day that Jamie moved to Plymouth on the 9th especially as the CiC nurse had recommended that the HV was involved regarding Jamie's loose bowels. If there had been a need for support, health visiting and social care agencies would have been unaware of her presence, and this may have created barriers to receiving assistance.

4.4 On 21/08/23 the Health Visitor (HV) in Plymouth spoke to the Devon HV team for a verbal handover. They were advised that Jamie had no unmet health needs but did not receive any information about Jamie's background, the reasons why she was in care or a copy of her CiCRHA. All they knew was that she had had several changes in living arrangements. Devon had already sent some information, but it had never been received. The transfer of more detailed information about Jamie's background would have given the HV a clearer understanding of her potential health needs, allowing a more proactive approach with her new parents. The specialist CiC nurse in Plymouth did review the RHA, she checked that Jamie was making good progress and a home visit had been booked by the HV. This RHA was added to SystmOne which is a shared record keeping system to which the PHN team have access. There was a missed opportunity for the HV to have viewed the report, but they were not aware of its existence. Adding a step to notify the HV of relevant reports being uploaded to SystmOne might prevent this happening in future. It is also worth noting that the RHA did not mention Jamie's birth parents use of drugs and alcohol. This could have significant implications for Jamie in the future e.g. Foetal Alcohol Syndrome and so is an important omission. HVs need detailed health information for the children they support including relevant information about their birth parents. This also applies to the child's GP. The relevant professionals should request this if it is not forthcoming during the handover of care.

4.5 On 24/08/23 a statutory Child in Care review took place as a video conference. The Adoption South West SW was present in the home with Alex and Jamie and Jamie's SW was online.

Lucy, like many parents who adopt, had already returned to work at this point and so was not present. She did make it clear in conversation with the author (via the police) that she would have made herself available if she had been informed that she needed to be there and that her employer would have supported her attendance. Jamie was observed on the screen with Alex and appeared settled and happy. No concerns were identified. This was an important review for Jamie and her new parents, who were all still at an early stage in their relationship, and best practice would have been for Lucy to have been present. The timing of meetings needs to consider the availability of any parent who has returned to work as not all employers are flexible and allow time off. Parents also need to understand they have a responsibility to attend and take reasonable steps to achieve this. Neither the CiC nurse nor the HV were invited to this meeting. Had they been present this could have contributed to the shared understanding of Jamie's needs for all parties. The invite list for CiC review meetings should include the CiC nurse and HV. For a statutory review to take place Jamie's SW should have been present in the home.

5. Formal Placement of Jamie in Alex and Lucy's care

5.1 On 30/8/23 a Placement Order was granted for Jamie. Her birth parents did not oppose this order. The following day Jamie's SW met with her and Alex during a visit with her birth parents at the contact centre. She observed and documented positive interactions with Jamie "smiling and cuddling into Alex." Jamie was teething and starting to cruise around furniture, which indicated she was meeting normal developmental milestones for a 10-month-old.

5.2 Once a Placement Order is granted the Adoption Agency Regulations [AAR 36.4], "*Require the agency to ensure that the child and prospective adopter are visited within one week of the child being placed and then at least once a week until the first Adoption Plan Review. These visits should be shared wherever possible between the child's Social Worker and the Supervising Social Worker; clarity should be obtained from the outset about which Social Worker will conduct each visit*." It also states that, "*The adopters' Supervising Social Worker will also carry out visits. At a minimum, the first visit after the placement must be within 1 week; thereafter visits will be weekly until the first review and then monthly. Visits may be more or less frequent as set out in the Adoption Placement Plan or if circumstances so require or as agreed in supervision. On occasion it may be helpful for joint visits to be undertaken by the child's Social Worker and the prospective adopters' Supervising Social Worker*."

5.3 On 07/09/23 the HV visited the home and observed Alex and Jamie together. She noted a "*warm reciprocal relationship*" and did not identify any health needs. Lucy was not present and as this was the first visit to a family that had come together very quickly, involving a child who had experienced previous trauma and multiple moves between carers, it would have been best practice to see both the parents together. The HV reflected that it is often a challenge to see the other parent who has gone back to work. Not having the background information about why Jamie was in care would have made it more difficult for the HV to ask pertinent questions of Alex about Jamie's progress. Routine enquiry about Domestic Abuse

was discussed at this meeting, however, this was the only occasion it was mentioned by any professional. Domestic abuse is not a feature of this review, but it is helpful to remind all professionals of the need to ask about Domestic Abuse on more than one occasion and with both parents.

5.4 The HV was aware that Alex and Lucy were both health care workers. It can be exceedingly difficult for health professionals to admit vulnerability to each other because they are often assumed to have a high level of knowledge and coping skills. However, these were two new parents who had quite quickly fostered a child with a complex history, whose behaviour would highly likely be impacted by this trauma both now and in the future. It is positive to note that HVs in Plymouth are aware of how difficult it can be for any professional parents to ask for help and that they take specific steps to mitigate this in their questioning style. However, given that the HV did not know Jamie's history, this would have made it more difficult to know what pertinent questions to ask. Even though anyone planning to foster or adopt has gone through a rigorous assessment and training period, it is still a huge challenge to parent a child for the first time and professionals cannot solely rely on the adoption assessments for reassurance. The HV assessment was holistic in nature, and this was important as Jamie's development and behaviour may have been influenced by her previous trauma. All parents who foster or adopt, particularly for the first time, need to be given at least the same support as parents who have just given birth and probably more. Where that parent is a professional person, all parties need to be mindful that they may struggle to show vulnerability or ask for help and the planning of reviews and questions needs to take this into account.

5.5 The following day a Permanency Planning meeting was held virtually by video conference, Alex was on the call with Jamie, but Lucy was not present. Jamie was happy and progressing well and no concerns were noted.

5.6 Adopt South West undertook a home visit to the family on 05/10/23 to check in with the couple and saw Jamie. Shortly after this Jamie had final contact with her birth parents. These were separate appointments on the 10/10/23 and 13/10/23 and her SW was present. The SW reported no concerns.

5.7 Jamie was brought to a Child Health clinic on 10/10/23 and was making good progress.

5.8 A further permanency planning meeting took place on 19/10/23 again by video conference. Alex attended but Lucy was at work. This was a missed opportunity to make plans to engage with Lucy and see the family all together. Alex reported that Jamie "was teething and a bit grouchy" but also mentioned that she was "enjoying the baby sensory group and thriving." Professionals were in support of Alex and Lucy formally adopting Jamie at the Adoption Matching Panel meeting in November. It is concerning that the panel made this recommendation without the backing of the required statutory reviews. Jamie should have been reviewed after one week and then six weekly as a minimum but had no statutory reviews since her Placement Order some ten weeks previously. Instead, social workers relied

on her being seen during other non-statutory contacts, one of which was a virtual meeting, and most did not involve Lucy. This is a significant piece of learning for the system.

5.9 Adopt South West visited the home and saw Alex with Jamie on 26/10/23. Jamie was asleep in her cot and appeared settled but they had all recently had colds. All was going well.

5.10 A student HV completed a 9–12-month review on 09/11/23, which is part of the universal core visits for children. There are three levels of HV support in Plymouth; Universal (the core home visiting programme offered to all families); Universal plus (enhanced visiting to support with a short-term problem) and Universal Partnership Plus (an enhanced offer for more complex families based on individualised identified health and developmental needs). When the HV in Plymouth first visited Jamie, she placed her on a universal HV pathway. She had previously been on a Universal Partnership Plus pathway in Devon due to her traumatic start in life, but this had been reduced to Universal before she was transferred to Plymouth. On questioning the Plymouth HV, this was an error, and she meant for Jamie to be on the Universal Plus Pathway whilst she was in foster care. The computer system used by HVs has a drop-down box that allows staff select the correct level of service. Unfortunately, on this occasion the wrong box was checked indicating a universal service, but the HV was providing a universal plus level service. The Plymouth HV was unclear that a child in care should receive the Universal Partnership Plus, irrespective of whether they have any unmet health needs. Plymouth Public Health Nursing have since decided that all children in Foster to Adopt placements should receive a Universal Partnership Plus HV offer although this does rely on the PHN service being notified of the foster to adopt arrangements and being invited to multiagency meetings. This decision along with the rationale for it needs to be further clarified to HVs. It would also be helpful for Devon to review the clarity of their offer to their staff.

5.11 At this point Jamie was meeting all her milestones, but the HV did observe some bruising. Jamie had bruises on the left side of her forehead which Alex reported was from a fall. She had a bruise to her right knee, reportedly from crawling on a wooden floor and a small bruise on her back which Alex said was from the child guard on the corner of the coffee table. The HV demonstrated good professional curiosity in checking that this bruise corresponded with the height of the coffee table. Bruising on prominent bony areas are common in children who are newly mobile. Bruises on the forehead and knees are usually accidental. Bruises on the back are more unusual, but the HV appropriately questioned Alex and checked that the mark matched the proposed mechanism of injury and was in line with Jamie's developmental stage. The HV's assessment was that these bruises were all accidental.

5.12 For children that have experienced trauma in their early life there are often problems with attachment. As part of their trauma informed holistic assessment the HV assessed Jamie's relationship with her adoptive mother noted that Jamie appeared happy, confident and there was "*emotional warmth*." However, children with poor attachment can demonstrate behaviours such as clinginess or a lack of fear of strangers which can mean they seek attention from any adult (NSPCC 2021). It was still early days in their relationship, so Jamie

was still forming an attachment to her new parents. A more in-depth consideration into Jamie's behaviour in relation to her previous trauma by the HV would have been helpful, although this might have been hampered by the lack of information the HV had about Jamie's background.

5.13 Alex described a good network of support. The house was clean, and Jamie was appropriately dressed for the season in a dinosaur tracksuit. The family Jack Russel Terrier was also seen and appeared to be well cared for. This is relevant because there is an association between abuse to animals and abuse to children, the converse is also true. The student HV recommended that Alex take Jamie to the GP to review the bruise on her back. Alex did take Jamie to the GP as requested and no concerns were raised. The GP observed Jamie to have a few patches of eczema. The HV decided on a Universal Health Visiting offer going forward. As discussed previously this should have been on a Universal Partnership Plus and actions have already been taken to ensure this is what happens in the future.

5.14 The Adoption Matching Panel took place on 15/11/23 attended by ASW and Jamie's SW and there was a unanimous recommendation to support the couple's match with Jamie. Appendix A of the Adoption Regulations requires, "Confirmation that any referees have been interviewed, with a report of their views and opinion of the weight to be placed thereon and whether they are still valid." The assessing SW from Adopt South West did speak to the couple's referees, but it is not clear from their notes if this was by phone or face to face. The notes are vague, and it does not appear that there were any challenging questions asked. Unfortunately, this SW has now retired and so was not available to answer questions. However, the adoption panel did not challenge this before making their recommendations. The Adoption Matching Panel should ensure that all assessments are completed in line with statutory processes and are of high quality before supporting a match, even if the professionals involved have a unanimous positive view. This is to ensure that legal requirements for adoption are met, that members of the panel are not unduly influenced by singular strong opinions or "Group Think," and there is evidence to support their recommendation. Group think can lead to unconscious bias and professionals being over optimistic about a situation rather than having recourse to the evidence when making decisions. In Jamie's case this evidence was incomplete due to missing statutory reviews and poor-quality references. The Adoption Matching Panel should take steps to ensure the evidence on which they base their recommendations is of high quality and meets statutory requirements. It may be helpful to consider some specific training around unconscious bias for the staff involved.

5.15 Jamie's SW visited the home on 23/11/23 and saw Jamie and Alex. The family had recently been on holiday and Jamie had had a cold but was now better. Alex reported that "*Jamie fits in perfectly with their family*" and they have a "*close bond*." Jamie was observed to be playing and moving about on the floor, she appeared happy, and no concerns were noted. Jaime had only been living with the couple for just over 3 months at this point and for a child who had had multiple changes in placement, was a victim of domestic abuse and had parents who were substance abusers, it is highly unlikely she would have securely attached to Alex. Greater curiosity around this point would have been helpful from professionals,

although may have been hampered by the couple being viewed through "rose tinted spectacles" and over optimism from all parties about the placement.

6. Review health Assessment (RHA)

6.1 On 16/11/23 a further RHA was allocated to the Specialist CiC nurse in Plymouth. They followed the standard practice recommendation and asked for a report from Jamie's SW and GP. Her SW replied very promptly to say that Jamie was on antibiotics for her chest and had her first tooth but there were no concerns. Jamie's SW did mention that Jamie quite often had coughs and colds. This is not unusual for a child of this age but can be challenging for parents, especially if the child is not sleeping as a result.

6.2 This RHA took place on 11/12/23. The CiC nurse saw Jamie and Alex at their home. When she arrived, Jamie was sat in her highchair eating and was "very sweet and funny." Alex was very positive about how things were progressing, but she did express some concerns from Lucy about whether Jamie was bonding with her as well as Alex, given that she was at work during the day. She described how Lucy was putting in a lot of effort to make sure she did bond with Jamie, so she thought this would be OK. This conversation could have prompted plans to engage more effectively with Lucy who had been missing from many of the visits.

6.3 During the health assessment it was noted that Jamie was presenting age-appropriate behaviour. Her height and weight were on the 50th centile which was appropriate for Jamie and there was a discussion about dental care, health promotion and the possible impact of her previous trauma on her behaviour and emotional wellbeing going forward. This is all standard practice. Alex also mentioned that Jamie had a bruise on her right ear (pinna) from falling off a play horse onto a mat in soft play. The nurse checked around and behind the ear and found no other marks and was happy to accept Alex's explanation in the context of a spontaneous and plausible story on a background of no concerns about her care. This bruise and the explanation were remarked on in her report. Because she had no concerns, she did not take this to supervision.

6.4 Bruising on the pinna is known to be more commonly associated with physical abuse than accidental injury. This is an incredibly significant red flag in a non-mobile child, but it is still an important sign in one that is mobile, like Jamie. In a child who is walking the odds of a bruise on the ear being non-accidental (i.e. due to abuse) rather than accidental are between 1.5 and 7.1 to 1 [Kemp et al, 2013]. These bruises therefore deserve thorough consideration as a sign of abuse [NICE 2017].

6.5 The specialist nurse was aware of the significance of bruising on the pinna in a non-mobile baby but was not so clear about the implications for a mobile child. She did exercise good professional curiosity in both her clinical examination and questioning but there was a missed opportunity to discuss this in supervision and consider if a further medical review may have been appropriate. The Plymouth (Livewell South West) Safeguarding Children Policy used by professionals states, "All non-ambulant children who are seen to have unexplained bruising or marks, (or marks/bruising without an acceptable explanation) should

always prompt consideration or suspicion of maltreatment and immediate referral to Children, Young People & Families Services, and an urgent paediatric opinion. This was not particularly helpful as it only covered non-mobile children. It is a recommendation of this review that the guidance is extended to cover the current evidence regarding which injuries in a child under 2 years need to be considered as non-accidental.

6.6 Had this been taken to supervision, it is possible that no further action would have been taken but given the increased risk of this type of injury being non-accidental, it may have been appropriate to discuss it with Children's Social Care (CSC) and consider a Strategy meeting. It is likely that the threshold for a strategy meeting would not have been met but if it had, the outcome could have been a child protection medical. This opportunity for further discussion and to consider potential actions to clarify exactly what happened was missed. It is recommended that all professionals discuss cases in supervision where they have seen marks on a child that have a known association with non-accidental injury, even if there appears to be a satisfactory explanation. This will protect both children and professionals.

6.7 The RHA report was written, quality assured and sent to Devon on the 28/12/23 but was not uploaded to the Devon system until 04/01/24 some 24 days after the RHA visit (15 of which were working days due to the Christmas period). The recommended standard in Devon is that these reports should be added to the child's record within 72hrs. It was sent to Jamie's SW but there is no evidence that she ever read it. Had she done this she might have questioned the bruise further and this could have been a second opportunity to clarify what had happened. It is unlikely the bruise would still have been present some 10 days later but certainly not 24 days later. Both the delay in the report and the fact that the SW never read it are missed opportunities to potentially safeguard Jamie.

6.8 Normally when a report is uploaded for a child, the SW is notified by email. It may be helpful for SW managers to have clarity about any reports on the system which have not been read, as all reports contain valuable information about a child in care. The planned implementation of a new recording system for CSC in Devon creates an opportunity to include this facility.

7. Child in Care Review

7.1 Three days after the RHA there was a Child in Care Review meeting which took place by video conference. This was chaired by the Independent Reviewing Officer, Alex and Lucy were present, and Jamie was also seen on the screen. Although virtual meeting became the norm during the covid pandemic this was over 2 years later, and it is likely the meeting was virtual out of convenience than need. The IRO handbook statutory guidance states, "*It is important that the IRO also meets with or observes the child in the placement so that consideration is given to the suitability of the placement to meeting the child's needs*." It is doubtful that a virtual meeting will meet these statutory requirements, and it is a recommendation of this review that CiC Reviews are held in person unless there are exceptional circumstances.

7.2 The IRO handbook also requires that IRO addresses the following issues:

- *the report of the most recent assessment of the child's health and whether any change to the arrangements for the child's health are necessary or likely to become necessary before the next review, in order to ensure that the child's health needs are met and not neglected. This RHA should be provided at least 3 working days before the review.*
- *whether the child is being visited by the social worker at the minimum statutory intervals*

7.3 The parents reported that the HV was pleased with Jamie's progress and had no concerns. The Independent Reviewing Officer (IRO) and SW were happy to accept the parents report but should have heard this information direct from the HV, who was not invited to the meeting. Professionals should not rely on parents to represent another professional's view. Perhaps because the couple were health care workers there may have been an unconscious positive bias particularly towards their reporting of health information. The IRO and SW were also not aware that an RHA had recently taken place and had not read the report. The RHA only took place three days before the meeting and so this would not have allowed them time to read the report. Had they been aware of the RHA, the meeting could have been timed to allow them to see the report or the CiC nurse could have been invited to the meeting. This would have afforded an opportunity to ask questions about the bruise and potentially to escalate concerns. IROs should ensure that health information is provided by professionals rather than parents and that actions are taken around missing information.

7.4 All professionals in the meeting were universally positive about Alex and Lucy's care of Jamie. They were "relieved that Jamie was now in such a lovely family" and it may be that this was the reality. However, there is a danger when all professionals are expressing a positive view that anyone who may be considering raising a concern finds it very difficult to do so. There can also be "Group Think" and participants fail to challenge or be curious about what is not known. This can lead to poor quality decisions. Therefore, it is especially important that there is objective evidence in the form of statutory reviews that are high quality and not just a reliance on how professionals "feel." The IRO has a lead role in CiC review meetings and should ensure the relevant professionals are present (including the HV and CiC nurse) and the group are aware of, have read and understood any reports before taking a final decision as well as challenging any missing information. In Jamie's case the HV report, RHA and some of the statutory SW visits were missing. The IRO handbook states that the IRO could consider an adjournment of the meeting if they are "*not satisfied the local authority has complied adequately with all the requirements relating to reviews*" and that, "*As part of the monitoring function, the IRO also has a duty to monitor the performance of the local authority's function as a corporate parent and to identify any areas of poor practice*". Devon CSC should consider auditing the role of their IRO in relation to CiC meetings against the standards in the IRO Handbook to inform the actions required in their ongoing quality assurance.

7.5 On 28/12/23 the Named Nurse for Children in Care reviewed and quality assured the RHA. She did not feel that the bruise on Jamie's ear was of concern, given that the explanation seemed satisfactory. It is positive that this quality assurance is part of the normal process but was a missed opportunity to bring it up in supervision with the author of the report. It would

be helpful to clarify with staff the requirement for cases that should be brought to supervision.

8. Social Work visits

8.1 In January the Adoption SW visited the family and was happy to see Jamie walking with her walker and chatting to her parents. She offered support to Alex and Lucy. The same positive comments were made by Jamie's SW who visited in January 2024 and met with Jamie and Alex, Lucy was back at work.

8.2 Jamie's SW visited three months later (March) and again met with Alex and Jamie but not Lucy. Alex told her that Jamie had been attending a childminder in preparation for her going back to work in 6 months' time. Jamie was now walking and was seen to seek comfort and cuddles from Alex. The SW reported no concerns, but this could have been an opportunity to explore why Jamie had started at the childminder at quite an early stage before Alex went back to work. This could have been evidence of an organised parent or one that was struggling being at home all day with a child and needed a break. The latter option does not necessarily indicate concern as all parents can find this a struggle at times, but it could have prompted a deeper conversation about how Alex was feeling about parenthood. There is no record in the Local Authority that Jamie was with a registered nursery or childminder, but the parents have provided this information during the review and confirmed that the childminder was registered. It is not clear why the Local Authority were unable to identify her at the time, but this review has not included information from the childminder.

8.3 On 28/03/24 the Adoption SW visited the home and met with both parents and Jamie; all was going well. On 08/04/24 the Adoption Order was granted by the court, and Jamie was now legally adopted by Alex and Lucy. Jamie had been living with the couple for just over 7 months at this point.

8.4 The following day Jamie's SW had a virtual meeting with Alex and Lucy to discuss meeting with Jamie's birth parents. Jamie was observed in the background walking around the kitchen and saying a few words. Jamie was then removed from the Children in Care caseload as due to the adoption she was no longer "in care." On 22/04/24 Alex and Lucy were closed to ASW. This is all standard practice.

8.5 The final visit from Jamie's SW took place on 15/05/24 with the purpose of saying goodbye to the family. Both parents were at home and Jamie was walking and talking. The SW commented that, "*Your Mummy told us that you fall over lots and get bruises. They said you fell out of your bed twice the other night. They said you also managed to poke yourself in the eye and I noticed a red spot [subconjunctival haemorrhage]. You are now competent on your feet; you are fast and have no fear*." She also noted that Jamie was happy and settled and had a good bond with both Lucy and Alex. The family were delighted that the adoption was now formal and thanked the SW, giving her a card and a box of biscuits. The family were formally closed to CSC.

8.6 The SW had supervision on the day before she visited Jamie. She did not take the bruising or subconjunctival haemorrhage to her next supervision or her line manager as the case was being closed. She recalls being satisfied with the explanation given, but the notes are brief and do not describe the bruises or explore how they occurred. The overwhelming positivity about this couple, the fact they gave the SW a gift and that she was about to close the case, may well have all been factors that limited her curiosity around the marks that she was seeing on Jamie. It would have been challenging to bring up the possibility of a non-accidental injury at such a lovely visit. However, her line manager could have challenged her on this and supported her to request more detail, but this did not happen. This is another opportunity where supervision could have supported professional curiosity as well as reminding professionals that even though they are closing a case, if they see or hear something of concern this deserves as much scrutiny as when a case is first opened.

8.9 Subconjunctival haemorrhages are another injury that has an association with non-accidental injury, particularly with Abusive Head Trauma (or shaking). Whilst this is highly likely to be due to abuse in a non-mobile child, Jamie was ambulant at this time, so this could have been accidental but there was still a risk she had been harmed. The TEN-4-FACES-p acronym [paediatric pearls] would be helpful to highlight amongst professionals. This is an evidence-based tool with a high degree of sensitivity (81.5%) and Specificity (87.6%) of picking up abuse [Raut et al, 2025]. It states that if bruising is observed with any of the following components, then a senior review should be sought due to the risk of non-accidental injury:

- **TEN** – **T**orso, **E**ars and **N**eck
- **4** – months or younger – any bruise, anywhere
- **FACES** – **F**renulum, **A**ngle of Jaw, **C**heeks (fleshy part), **E**yelids, **S**ubconjunctiva
- **P** – Patterned bruising e.g. that looks like a slap, grab or loop mark

8.10 Had the previous bruise on the pinna been known to the SW, she may have seen this in a different light. Had the conclusion been that Jaime was being abused; this was potentially a missed opportunity to instigate safeguarding processes.

9 Summary of SW visits in relation to statutory guidance

9.1

ASW SW	
Jamie's SW	

Relevant period	Dates	Who visited?	Details	Statutory?	Unannounced?
Transition period - 3 visits required	20/07/23	ASW SW	In person and seen with both parents	Yes	No
		Jamie's SW	In person and seen with both parents	yes	No

	02/08/23 Midway review	ASW SW	Gave positive feedback	Yes	No
		Unclear if CSC visit took place as Jamie's SW was on leave	Unknown	Unknown	No
	09/08/23 Placement Day	Jamie's SW	Home visit, seen with both parents. This is the only recorded time that Jamie's bedroom was seen	Yes	No
Placement in Foster care to Adoption During this period there should have been a visit within one week of the placement and then visits at intervals of not more than 6 weeks during the first year. At least one of these should be unannounced [Devon's Children and Families Procedures Manual]	24/08/23	ASW SW	Home visit with Alex and Jamie, Lucy is back at work	Yes	No
		Jamie's SW online	Jamie and Alex seen virtually during CiC review	No	No
	01/09/23	Jamie's SW	Supervised contact with Jamie's birth parents, Alex and Jamie seen	No	No
	10/10/23	Jamie's SW	Supervised contact with Jamie's birth parents, Alex and Jamie seen	No	No
	13/10/23	Jamie's SW	Supervised contact with Jamie's birth parents, Alex and Jamie seen	No	No
	26/10/23	ASW SW	Home visit with Alex and Jamie	no	No
	23/11/23	Jamie's SW	Alex and Jamie seen at home	Yes	No
	14/12/23	Student CSW	Alex and Jamie seen by student SW at home and CiC review held virtually	No	No
	09/01/24	ASW SW	Home visit with Jamie, Alex and Lucy	Unclear	No
	25/01/2024	Jamie's SW	Home visit to Jamie and Alex, Lucy is at work	Yes	No
	28/03/24	ASW SW	Home visit, Jamie seen with both parents	Yes	No
Post adoption visits	09/04/24	Jamie's SW	Virtual meeting with Alex and Lucy, Jamie is observed in background	No	No
	10/04/24	Jamie's SW	Last meeting with Jamie's birth parents, both parents present	No	No
	15/05/24	Jamie's SW and student SW	Farewell visit in person, both parents and Jamie seen. Student completed life story work	No	No

9.2 As can be seen from the table above, between the end of Jamie's transition period until her adoption there were only four home visits by Jamie's SW and one of these was completed by a student SW. The first visit should have been within a week of Jamie's placement but there was no statutory visit until over 3 months later. The ASW SW did visit but this was over 2 weeks later.

9.3 There was only one occasion on which Jamie's bedroom was seen and only two where both parents were present. There were no unannounced visits which are very valuable to see what normal family life looks like for the child. This represents a period of over 7 months and a time of foremost importance to both Jamie and her parents. ASW visited on four occasions. There was an over reliance on virtual reviews and supervision visits with Jamie's birth parents to form part of the family's assessment and it is very unlikely these would meet the rigor of a statutory review.

9.4 The fact that Jamie's bedroom was only seen once is significant. "A common finding from serious case reviews is that social workers do not understand the child's world and there is no better opportunity to develop and build this understanding than to spend time in their home. It is essential that social workers do not remain in the room the family has taken them to, be it the front room or kitchen, for the duration of the visit. They need to see where the child sleeps and if there are concerns about neglect, the bathroom/toilet which can give a good idea of hygiene. There have been several high-profile child deaths where it was ascertained that even those professionals who had visited the family home had little idea of the child's living conditions. After Daniel Pelka died it was discovered that he spent much of the time before his death locked in an unheated box room, with just a filthy mattress. After Khyra Ishaq's death it was discovered, she had to sleep in a room with one mattress with her five siblings and the kitchen door was kept locked. The kitchen was full of food, but Khyra was emaciated at the time of her death." Joanna Nicolas, 2025. Although there is no evidence to suggest Alex and Lucy were neglecting Jamie, a regular review of the child's bedroom contributes to the rigor of a statutory assessment and was missing in this case. The importance of unannounced visits and seeing a child's bedroom to really understand their world should be highlighted to Devon CSC professionals.

9.5 Alex and Lucy were only seen together on two occasions. This is another significant gap as it curtailed much of the assessment of them as a family. Although this was a professional couple who were always seen in a positive light, one must not forget that they were new parents to a child who had experienced previous trauma and was exposed in utero to drugs and alcohol. Adoption UK state that, "50% of prospective adopters found the process so difficult that they wondered if they could continue; 54% of new adopters experienced stress, anxiety or the symptoms of post-adoption depression during the early weeks and 56% of established adopters faced significant or extreme challenges." This highlights how important support for parents is during the foster to adopt process. Alex and Lucy were entitled to and should have had a greater level of support and professionals should have sought a deeper understanding of how they were really feeling, given they may have struggled to show vulnerability. Professionals should have regularly spoken to them together and separately. Lucy's voice was rarely heard, and she might have provided some additional insights into a

more nuanced understanding of the family and therefore Jamie's world. This gap should have been highlighted during the statutory reviews and through line management.

9.6 The couple made the following comment about their post adoption support: "*Post adoption support was useful and available. We had a good understanding of our daughter's needs. She was thriving and enjoying life prior to her accident. We both work for the NHS and were fully prepared by the adoption agency/adoption agency workshops to better understand the challenges our daughter had already experienced and how this could affect her in life.*" Whilst it is good to hear that they felt prepared and supported, one must be mindful that the response was co-ordinated by the police and so they may not have felt comfortable to share anything that might have suggested they were struggling. It also further highlights the point that as health care workers they may have struggled to show weakness.

9.7 During Jamie's time in care her SW had three different managers providing case supervision. It appears, from discussion with the SW, that some of these managers may not have had a clear understanding of the adoption process. Case supervision was sporadic, and reflection was limited to Jamie's lived experience and the suitability of the adopters. There was no action taken with regards to visiting patterns. The turnover and experience of SW managers appears to have had a negative impact on Jamie's care.

9.8 There was no post-adoption support after the farewell visit. Alex and Lucy could have requested support but given that they were a professional couple who may have found it more difficult to ask for help, professionals could have had a lower threshold for going in to check that things were still OK. This was a time of immense joy for the couple as they were now legally Jamie's parents but also perhaps a time when they felt the weight of that responsibility without the support that had been available to them previously. The universal services provided by the HV and GP should be highlighted to parents by both ASW and CSC and post-adoption support should be actively encouraged.

10. The Day of Jamie's Head Injury

10.1 On the day of her injury, Alex reported that Jamie was teething, and they had been cuddling on the sofa whilst Lucy went to the shops and took the dog for a walk. Alex went into the kitchen to get some Calpol (paracetamol) for Jamie and Jamie followed her, picking up a book on the way. Alex had her back to Jamie as she reached into the fridge for the bottle but heard a thump and then Jamie scream. When she turned around Jamie was on her back on the tiled kitchen floor and her eyes rolled up and she was stiff. She appeared to have slipped and fallen backwards, hitting her head on the hard floor. There was nothing else she could have hit her head on. Alex took her upstairs and called Lucy. Jamie started making gasping type breathing movements and so Alex called an ambulance.

10.2 The ambulance arrived promptly, and the paramedics found Jamie lying on a bed upstairs. She was unresponsive and her breathing and abnormal posture suggested a serious brain injury and a substantial risk of death. She had a boggy swelling on the back of her head and

bruising on both temples. The paramedics transferred her urgently to Derriford Hospital which was only 4 minutes away and handed over to the paediatric team who stabilised Jamie ready for transfer to Bristol Children's Hospital (BCH). She was examined by a paediatrician in Derriford who noted bruising to her left temple, (he could not examine the back of her head or body as she was having a breathing tube inserted) a thin line of petechiae (small coloured spots due to broken blood vessels) on the right side of her neck, a faint bruise on the upper right part of her abdomen near the edge of the ribcage and bruising on her arm and foot. There were no other marks found on the limited examination possible.

10.3 Alex and Lucy explained that the marks on Jamie's neck had occurred a few days ago when she had almost fallen down the stairs and Lucy had caught the back of her clothes to stop her falling. The clothing around her neck had caused the mark. Lucy also explained that the bruise on Jamie's abdomen was from her knocking it on a bedframe a few days ago. The mark on Jamie's neck could have significance in that this is one of the areas already discussed that are more commonly associated with non-accidental injury. This only became known at the point that Jamie was in hospital so if it had been non-accidental there was no opportunity to safeguard her, but with the bruise on the pinna and the sub-conjunctival haemorrhage, it does add to the pattern of concerning marks found by professionals. The bruising on the arm and foot are unlikely to be of any significance.

10.4 Scans showed that Jamie had a linear fracture of the left parietal bone (of the skull) that was extending into the sagittal suture. There is a large blood vessel below the sagittal suture (the sagittal sinus) that had ruptured and caused a large blood clot (haematoma) which was leading to raised intracranial pressure. There was also extensive damage to the brain. Jamie was transferred to the BCH and had emergency neurosurgery – a craniotomy and evacuation of the haematoma. After further review, she was found to have extensive retinal haemorrhages (bleeding at the back of the eye) which it was felt were unlikely to be due to the surgery. This combined with the extensive global brain injury was very unlikely to have been caused by a low energy domestic accident with a child falling from their own height. These injuries are more commonly seen when there is significant energy transfer (high impact) raising the possibility that someone punched or pushed Jamie. As Alex was alone with Jamie at the time of the injury, the police arrested and questioned her, and Section 47 enquiries were commenced by CSC. Unfortunately, at the time of writing Jamie remains in hospital, some 7 months after this incident, and her outlook is poor.

10.5 Jamie's parents have not been questioned about this incident as at the time of writing there was still a live criminal investigation, but they did make this comment via the police, "*Parenting our daughter has been the most important and rewarding experience, her freak accident has been absolutely devastating but we have and will continue to stay by our daughter's side throughout all the challenges she may face. Our commitment to our daughter will continue and will not change regardless of future challenges*."

11. Possible Impact of Parent's Sexuality

11.1 Under the Terms of Reference of this review the author was asked to examine the possible impact of the parents being a same sex couple. There has been no indication from any professionals that they felt uncomfortable with or influenced by the couple's sexuality. There is some evidence of a possible impact on professionals with regards to them both being NHS clinical staff but nothing that relates to their sexuality.

11.2 "*In-depth research into the experiences of adoptive families headed by same-sex couples suggests that children adopted by gay or lesbian couples are just as likely to thrive as those adopted by heterosexual couples. It also reveals that new families cope just as well as traditional families with the big challenges that come with taking on children who have had a poor start in life*," [New Family Social]. Studies indicate that children raised by lesbian women do not experience adverse outcomes compared with other children [Anderssen et Al 2002].

11.3 The number of LGBTQ+ adopters approved by ASW at the time of Jamie's adoption was around 20% so this is by no means a rare occurrence. This review can find no material evidence of any impact of their sexuality on what happened to Jamie.

12. Reflections against National Learning

12.1 Coram BAFF have undertaken a significant piece of research relevant to this review, "Safeguarding Children living with Foster Carers, Adopters and Special Guardians: Learning from case reviews 2007–2019". Although this is now a few years old the themes outlined below still resonate.

12.2 Alex and Lucy's SW from ASW was involved with the couple from day one of their adoption application right through to the adoption being formalised. Whilst this may be positive in terms of continuity of care. The Coram BAFF research does highlight that this can lead to a lack of objectivity due to a sense of loyalty to "their foster carer" and this could cloud judgements. It can lead to an organisational culture where a supervising SW feels pride when the carer does well and a natural defensiveness when they are or may be criticised. The focus of assessments needs to be on the evidence rather than feelings and robust supervision can assist with this. Given the overwhelming positivity around this couple and lack of deep exploration, it may be helpful for ASW to consider if a change in SW would provide more objectivity.

12.3 In other cases in the review the SW's role was compromised when the foster carers were able to weigh the relationship in their favour. They cite a particular case where, "The parents presented as a well-educated and articulate couple who had been able to access resources and support previously. They were very well regarded by each of the agencies as good parents… Given how strongly this view was held, the injuries that the child sustained were never considered as anything other than childhood accidents." The balance of power between professionals and carer should be clearly examined with SWs retaining some respectful uncertainty, even when everything does seem positive. This uncertainty was

missing in Jamie's case and contributed to the difficulty that professionals had in "thinking the unthinkable."

12.4 Carers can present a positive impression that may lull practitioners into a false sense of security. They can shield themselves from professional scrutiny by avoiding direct professional contact and routine oversight. There is no indication that Alex and Lucy were avoiding oversight but Lucy's absence at most meetings might have indicated she was avoiding professional contact. Seeing the family together is an important way to understand the child's world. Professionals could have recognised this and taken steps to ensure they had contact with Lucy perhaps making use of the child health clinics available across the city that may have made access easier.

12.5 There is no one electronic health record for the child that all professionals can see and in Jamie's case the SW, HV and IRO never saw the RHA. It would be helpful for Devon and Plymouth CiC teams to consider what happens to their health assessments, so they contribute to a full picture of the child's health and background.

12.6 The Coram BAFF report also raises concerns about information sharing and cites a case where the SW who had most been involved with a foster carer in whose care a child died, was not invited to the CiC review and this oversight was not queried by the IRO. In this case it was the CiC nurse and the HV who were not invited, and the IRO did not take steps to remedy this. Poor information sharing forms part of almost all reviews where children have come to harm and organisations need to construct systems that actively support good information sharing if this trend is to be stopped. A standard invite and check list used by the IRO and SW for meetings to ensure the right people are invited and the correct reports and reviews are in place may be helpful to consider.

12.7 There are themes in the report relating to a change in local authority, as was the case here. They noted that there are no set procedures in place to ensure that when a child is moved from one local authority to another that all relevant information is transferred. There were handovers to CSC and the public health nursing team when Jamie moved from Devon to Plymouth, but they were not comprehensive, and not all the information got to its destination. Formalising a handover procedure for all the relevant agencies could reduce the chances of this happening in future.

12.8 The Rapid Review identified an LSCPR undertaken by Cardiff and Vale SCB that had similarities to Jamie's case. Elise Scully-Hicks was killed by her adopted father shortly after being adopted by him and his husband. There were no unannounced visits, and he was not often seen due to being out at work at the time of professional visits. Professionals viewed Elise's life through a positive lens and saw her injuries as childhood accidents, failing to see the patterns. These missed opportunities resonate with those found when examining what might have happened to Jamie.

13. Conclusion

13.1 This review has looked in depth at the antecedents to Jamie's serious head injury. In particular considering the parents adoption approval process; the specifics of foster to adoption in relation to Alex, Lucy and Jamie; the adherence to statutory visits by Jamie's SW and ASW; the role of the IRO; the effectiveness of statutory meetings; the role of the RHA and the supervision of staff working with the family. It has also considered the advice and guidance available to professionals at the time; the systems they use and how they shared information. This has led to thirty separate recommendations that are outlined in the table below. The conclusion that Jamie's accident was just that, an accident does not change any of these.

13.2 These thirty separate recommendations can be grouped into six categories:

- Information Sharing
- Meeting Arrangements
- Statutory Reviews
- Meeting Parent's Needs
- System Issues
- Professional practice

13.3 Information Sharing issues relate to handovers between teams when a child moves across county boundaries and whether these include all the relevant information. Also, ensuring that reports are stored in the correct place and are read by the right people.

13.4 Meeting Arrangements should include appropriate chairing and timing, with the right people in the room. Statutory reviews should take place in person in the child's home unless there are exceptional circumstances and should only go ahead when they are informed by high quality and complete information. Members need to be aware of unconscious bias and the risks of over optimism.

13.5 Statutory Reviews should take place in the child's home and the child's bedroom should be seen. SWs should not rely on ad hoc visits to replace statutory reviews although still recognise the value of information gained by them. It is also important that professionals hear from both parents and see the family together to properly understand the child's world. There should be some unannounced visits.

13.6 Meeting Parent's Needs is particularly important in the Foster to Adopt process as it brings additional stresses. Professionals need to understand how difficult it may be for parents who themselves are professionals to show vulnerability or ask for help and take steps to ensure they really understand how they feel about parenthood.

13.7 System Issues relate to how professionals understand the level of intervention required in the Foster to Adopt process, particularly in relation to Health Visiting. There are gaps in the

guidance for professionals around identifying non-accidental injuries in mobile children under 2 years that need to be addressed. Specific audits to inform quality assurance should be considered. The use of IT systems to identify gaps may be helpful. ASW should consider the balance of continuity vs objectivity when allocating SWs to work with adoptive parents.

13.8 And finally Professional Practice should recognise the valuable role that supervision plays in safeguarding and how managers can support this even when a case is about to be closed. IROs should ensure that health information is gained from professionals and not parents and chase up missing information. The role of trauma in a child's development needs to be explicitly outlined in reviews.

13.9 The following is a summary of the recommendations made by this review:

Category		**Recommendation**	**Paragraph**
Information sharing	1	Transition plans should be uploaded to the child's SW record	4.1
	2	Handover between HV teams needs to be robust and timely	4.3
	3	SystemOne notifications to HV of uploaded reports may improve information sharing	4.4
	4	Professionals need relevant information about birth parents to understand the health needs of the child	4.4
	5	Devon and Plymouth CiC Teams should review what happens to Health Assessments once completed, to ensure they contribute to a full picture of the child's health and background for all relevant professionals	12.5
	6	Formalising a handover procedure for all relevant agencies should be considered where a child is moving across boundaries. Where this exists agencies should be assured it is working	12.7
Meeting arrangements	7	Placement planning meeting should be chaired by SW managers	4.2
	8	The timing of meetings should consider the availability of parents who have returned to work and professionals should explain the importance of their attendance.	4.5
	9	Child in Care review meetings should include the CiC Nurse and HV	4.5
	10	Adoption Matching Panel meetings should ensure that decisions are only made about children when they are informed by high quality statutory reviews that involve both parents and take place at the correct time	5.8, 5.14 and 9.5
	11	Adoption Matching Panel members should consider formal training around unconscious bias	5.14
	12	CiC Reviews and Adoption matching Panel meetings should be held in person and not virtually unless there are exceptional circumstances	7.1
	13	A standard invite and check list used by the IRO and SW for meeting should be considered	12.6
Statutory Reviews	14	The child's SW should see the child in their home for the purpose of a statutory review	4.5

	15	Parents who foster to adopt should be made aware of the importance of seeing the family together for reviews and meetings and do their best to make themselves available	5.8
	16	The importance of unannounced visits and seeing a child's bedroom to better understand their world should be highlighted to SWs in Devon	9.4
	17	The importance of hearing from both parents during statutory reviews needs to be highlighted to professionals in CSC and ASW	9.5 and 12.4
Meeting Parent's needs	18	Parents who foster to adopt need to be given the same support as a parent who has given birth if not more	5.4
	19	Professional parents may struggle to show vulnerability and so all parties need to be mindful of this when asking questions	5.4
	20	Professionals should conduct in depth conversations with foster carers about how they feel about parenthood	8.2
System issues	21	HVs in Plymouth should be clear that children in foster to adopt placements require a Universal Partnership Plus offer	5.10 and 5.13
	22	Plymouth Safeguarding Children Policy should be extended to include advice around non-accidental injuries to recently mobile children (under 2 years). This should include the TEN-4-FACES-p (or similar) mnemonic	6.5 and 8.9
	23	The planned implementation of a new computer system for Devon CSC should consider providing SW managers with clarity about any reports added to the system that have not been read	6.8
	24	Devon CSC should consider auditing the role of the IRO in relation to CiC meetings against the standards in the IRO Handbook, to inform ongoing quality assurance actions	7.4
	25	The high turnover of SW managers in Devon and its possible impact on safeguarding needs to be considered by Devon CSC	9.7
	26	ASW should consider whether a change in SW once parents are approved for adoption may provide more objectivity	12.2
Professional Practice	27	As part of a holistic assessment professionals should specifically comment on the impact of trauma on a child's behaviour and attachment	5.12
	28	Marks on a child that have a known association with non-accidental injuries should always be discussed in supervision even if there appears to be a rational explanation. Staff should be aware of what needs to be brought to supervision	6.5, 6.6, 7.4
	29	IROs should ensure that health information is provided by professionals and not parents, where this information is missing, they should take action to obtain it	7.3
	30	Managers should support SWs to remain professionally curious and take concerns to supervision, even when they are about to close a case	8.6

13.10 The overarching themes of learning from this review are about the rigour of statutory processes and the role of supervision. Decisions were made about Jamie's care without the statutory evidence to support it and instead there was a reliance on how professionals felt about the parents. Whilst professional intuition is important and should feature in case recording, it should not be relied on exclusively due to the risk of bias but instead complement a secure evidence base. There was no point at which anyone questioned this positive view despite two incidents that had a significant association with non-accidental injury (the bruise on Jamie's ear and the subconjunctival haemorrhage). There was variability in the effectiveness of professional curiosity applied to questioning these marks and a sense that because the case was about to be closed (due to the formal adoption) SWs did not want to "think the unthinkable." Information about these marks was not shared or taken to supervision and so there was no opportunity for discussions about further actions. There were times when SW Managers appeared to be absent from the process and the scrutiny they could have provided did not happen.

13.11 Adoption Matching Panel meetings took place despite missing or poor-quality information and health professionals were not invited. There was no recognition that the panel were seeing an incomplete picture and decisions were not deferred until this was available, despite this being about Jamie's long-term future. The reliance on virtual meetings further inhibited a clear view of Jamie's world. The RHA was shared but never read by most professionals working with the family, even though it contained potentially vital information about bruising. Therefore, the opportunities to go back and potentially investigate further were lost. Because Jamie's SW did not know this information the second mark could not have been considered as a potential pattern. It is important that possible non-accidental marks are discussed more widely, even if at the time no further action is deemed necessary as this will enhance the awareness of potential future risks.

13.13 Finally it is important to recognise the exceptional skill and care of both the paramedics who attended Jamie, and the staff at Derriford and Bristol Children's Hospitals who together saved her life. Although Jamie's future remains uncertain, all the participants of this review recognise that clarity around what happened is vitally important to the family and hope that with the love and care of her parents, Alex and Lucy, Jamie makes a good recovery, thrives and enjoys life to the fullest.

References and Background Research:

Adopt South West, Fostering for Adoption (Early Permanence). Available online at: https://www.adoptsouthwest.org.uk/adopting-a-child/fostering-for-adoption/. (Accessed 7 Jan 25).

Adoption Agency Regulations 2005, UK Government. Available online at: https://www.legislation.gov.uk/uksi/2005/389/contents. (Accessed 7 Jan 25).

Adoption West, Early Permanence Planning Practice Guide: A practice guide for professionals working with children and families in care and permanence planning, A Lucas, August 2023.

Anderssen, N., Amelie, C, and Ytteroy, E.A., Outcomes for children with lesbian and gay parents: A review of studies from 1978 to 2000, (2002), Scandinavian Journal of Psychology 34(4): 335-351.

Cleaver H and Rose W, Safeguarding Children living with Foster Carers, Adopters and Special Guardians: Learning from case reviews 2007–2019, 2020.

Coram BAAF, Exploring Outcomes Relating to Adoption, 20 October 2023. Available online at https://corambaaf.org.uk/sites/default/files/Marketing/PRD/Adoption/Exploring%20outcomes%20related%20to%20adoption/Exploring%20permanency%20outcomes%20-a%20%20literature%20review.pdf (Accessed 7 Jan 25).

Coram BAAF, The Role of Fostering for Adoption in Achieving Early Permanence for Children, Dibben E and Howorth V, 2017.

DeRidder C.A., Berkowitz C.D., Hicks R.A., et al. Subconjunctival hemorrhages in infants and children: a sign of nonaccidental trauma. Paediatric Emerg Care 2013; 29(2): 222-226.

Devon County Council, Devon's Children and Families Procedures Manual, Social Worker Visits to Looked after Children, available online at: https://devonchildcare.proceduresonline.com/p_sw_visits.html#:~:text=Within%20one%20week%20of%20the,the%20child%20is%2018)%3B. (Accessed 6 Jan 25).

Devon Safeguarding Children Partnership, Bruising in Babies and Children, 11 Feb 23. Available online at https://swcpp-devon.trixonline.co.uk/chapter/bruising-in-babies-and-children (Accessed 19 Dec 24).

Dunstan et al, A Scoring System for Bruise Patters: a tool for identifying abuse. Arch Dis child 2002: 86: 330-333.

Gay, Lesbian and Heterosexual Adoptive Families: Family Relationships, Child Adjustment and Adopters' Experiences (Baaf) (2013), available online at https://newfamilysocial.org.uk/page-18253/8841840 (Accessed 12 Feb 25).

Kemp et al, Bruising in Children who are Assessed for Suspected Physical Abuse. Arch Dis Child 2014: 99: 108-113.

Kemp AM, Dunstan F, Nuttall D, et al, Patterns of bruising in preschool children—a longitudinal study, Archives of Disease in Childhood 2015;100:426-431.

Life Chances of Adopted Children Undermined by Battle for Government Support, Adoption UK, News, 2 July 2019. Available online at: https://www.adoptionuk.org/news/life-chances-of-adopted-children-undermined-by-battle-for-government-support. (Accessed 6 Jan 25).

Naresh Seeboruth, TEN-4-FACES-P Clinical Decision Toolkit, June 2022. Available online at: https://www.paediatricpearls.co.uk/wp-content/uploads/2022/06/TEN-4-faces-p-poster.pdf (Accessed 7 Jan 25).

NICE Clinical Guideline [CG90] Child Maltreatment: when to suspect maltreatment in under 18s. Available online at Recommendations | Child maltreatment: when to suspect maltreatment in under 18s | Guidance | NICE. (Accessed 19 Mar 25).

Nicolas J. Why do home visits matter in child protection, 2015, Abuse and Neglect in children, Community Care. Available online at https://www.communitycare.co.uk/2015/09/02/home-visits-matter-child-protection/. (Accessed 7 Jan 25).

NSPCC, Attachment and Child Development. 10 Aug 2021; NSPCC Learning. Available online at: https://learning.nspcc.org.uk/child-health-development/attachment-early-years. (Accessed 6 Jan 25).

Pierce et Al, Bruising Characteristics Discriminating Physical Child Abuse from Accidental Trauma. Pediatrics 2010: 125(1): 67-74

Plymouth Safeguarding Children Partnership, Building Support for Children, Young People and Families in Plymouth, Sept 2023. Available online at https://plymouthscb.co.uk/wp-content/uploads/2023/09/Building-Support-final-copy-2-edited-number.pdf (Accessed 19 Dec 24).

Preston S, Case Review Summary- Elise Scully-Hicks, SSS Learning, 16 Oct 2018. Available online at: https://ssslearning.co.uk/safeguarding-articles/case-review-summary-elsie-scully-hicks?srsltid=AfmBOopkAX8ye0xqPCR7Ju9gyH84JTSBoA670iE9kLrINOlqNz3R5Xi0. (Accessed 6 Mar 25).

Raut A, et al. Single Bruise Characteristics Associated with Abusive vs Accidental Injury. Pediatrics 2025: 155(3): e2024067932

Spitzer SG, Luorno J, Noël LP. Isolated subconjunctival hemorrhages in nonaccidental trauma, J AAPOS. 2005 Feb;9(1):53-6.

Statutory Guidance on Adoption for Local Authorities, Voluntary Adoption Agencies and Adoption Support Agencies, July 2013, Dept for Education, UK Government. Available online at: https://assets.publishing.service.gov.uk/media/5a7badc640f0b645ba3c5dff/adoption_statutory_guidance_2013.pdf. (Accessed 7 Jan 25)

Wood J, et al, Development of Hospital-Based Guidelines for Skeletal Survey in Young Children with Bruises, 5 Nov 2014. Available online at https://pmc.ncbi.nlm.nih.gov/articles/PMC4306798/pdf/peds.2014-2169.pdf. (Accessed 7 Jan 25).