Bristol Safeguarding Children Board

Serious Case Review

"AYA"

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Contents

1. Introduction

1.1. This serious case review has taken place following the death of Aya, who suffered non-accidental head injuries whilst in the care of her father, in the early morning of 25/12/2016. Paramedics were called to the house but were unable to save Aya and she died shortly after their arrival.

1.2. Aya's father was arrested on 25/12/2016 and charged with murder on 28/12/2016. At the court case on the 03/07/2017 he pleaded guilty to her murder and subsequently received a life sentence with a tariff of 15 years.

2. Rationale for carrying out a Serious Case Review

2.1. The local Constabulary referred the case to Bristol Safeguarding Children Board's Serious Case Review Panel (SCR) on the 29/12/2016. A panel meeting was held on the 20/01/2017 where it was determined that Aya's death met the criteria required to carry out a SCR. On the 1/02/2017 the Independent Chair of BSCB agreed with the decision which was based on the criteria as laid out in Working Together to Safeguard Children 2015 (Working Together), which refers to Regulation 5 of the LSCB Regulations 2006. Regulation 5 (2) states that;

"a serious case is one where:

(a) abuse or neglect of a child is known or suspected; and

(b) either;

(b)(i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the… (agencies)… have worked together to safeguard the child".

"Cases which meet one of the criteria (i.e., regulation 5(2)(a) and (b)(i) or 5(2)(a) and (b)(ii) must always trigger an SCR".

Aya's death met regulation 5(2) (a), abuse is suspected, and 5(2) (b) (i), the child has died.

2.2. There was limited agency contact (health agencies and Children Centres only) with the family prior to Aya's death. The review is therefore focusing primarily on those services when considering the research questions identified by the SCR panel.

3. Review Process

3.1.Scope and focus of the SCR

3.1.1.The panel identified the following key areas to be explored as part of the review. They were:

1) What can we discover about a case that seems to have limited preceding risk factors and minimal agency involvement?

2) What do professionals understand about the role of fathers in the antenatal and postnatal periods?

3.2.Organisations Involved in the Review

3.2.1.It was agreed that the following organisations would be required to contribute to the serious case review;

- GP practices
- Local Out of Hours GP service
- Local NHS Trust 1 (maternity services, acute and community midwifery)
- Local NHS Trust 2 (Acute Services) (Records only)
- Local Community Health CIC (Health Visiting)
- Hospital outside of Bristol (initial antenatal contact, Records only)
- Ambulance Service Foundation Trust (Records only)
- Local Constabulary (Records only)
- Children's Centre 1
- Nursery School and Children's Centre 2

3.2.2.The review panel was made up of senior representatives from the following organisations with the SCR author also acting as the independent chairperson. The independent author was Anne Morgan, an Independent Safeguarding Children Consultant with a health background both in paediatrics and safeguarding. She has considerable experience in carrying out reviews and is trained in the use of a systems approach. The following table identifies the review panel members:

Agency	Role
Independent Safeguarding Children Consultant	SCR Author, Anne Morgan
Local Authority Children's Social Care	Safeguarding and Quality Assurance Service Manager
Local Clinical Commissioning Group	Designated Nurse for Safeguarding Children
	Named GP for Safeguarding Children
Community Health CIC	Named Nurse for Safeguarding Children
Local Authority Education and Skills, Early Years' Service	Children's Centre Improvement Officer

3.3.Time period to be covered

3.3.1.The period of the review was from 17/12/2015 when Aya's mother presented for ante-natal care to Aya's death on the 25/12/2016 in Bristol.

3.4.Methodology

3.4.1.Working Together identifies the purpose of a SCR is to undertake a 'rigorous, objective analysis…in order to improve services and reduce the risk of future harm to children'.

The LSCB is required to 'translate the findings from reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children'.

This review was carried out in line with those principles and is proportionate to the incident.

3.4.2. A chronology was produced by the agencies involved and the professionals working with the family identified.

3.4.3. The model used was based on a broad systems approach. Due to the very limited and routine contact professionals had with this family a decision was made for review team members to meet with the professionals involved or the organisation's safeguarding leads, with the opportunity to discuss the report with the author. This contact was used as an opportunity for practitioners and safeguarding leads to understand the process, and discuss findings and recommendations.

3.4.4. The process was supported by the review group which met on three occasions and provided the author with additional information regarding services and helped with an understanding of the local picture. They also reviewed the draft reports, contributed towards the analysis of practice, the findings and suggested questions for the Board to consider.

3.4.5. Both parents were asked to be involved in the process. The Bristol Safeguarding Children Board Business Manager and the review author met with Aya's mother. Her views are incorporated within the report as well as in section 7. Aya's father was offered the opportunity to contribute but at the time of completion of the report he had not confirmed he wished to do so. Should this occur in the future it will be added as an addendum to the report. The parents were offered the opportunity to read the report before publication.

3.4.6. Some of the learning identified was outside of the terms of reference and was not directly relevant to this review. It has however, been included along with the practice changes that have occurred as it reflects findings from another SCR in Bristol.

4. Case Summary

4.1. Family Composition

Name	Date of Birth	Relationship	Ethnicity
Aya	22/06/2016	Subject	White other
Aya's Mother		Mother	White other (Eastern European)
Aya's Father		Father	White British

4.2.Narrative: History Prior to Review Period

4.2.1.Aya's mother moved to the UK from Eastern Europe about ten years ago. She met Aya's father at a spiritual retreat. They met again when Aya's mother became pregnant. Aya's father did not want to continue with the relationship but wanted to remain in Aya's life. They therefore lived together in a platonic relationship.

4.2.2.Aya's father had not had an easy adolescence or early adulthood and he had on occasions seen his GP and been treated with antidepressants. His parents had died two or three years previously leaving him a substantial amount of money which helped fund his misuse of alcohol and drugs at that time.

4.2.3.On the 03/12/2015 Aya's mother contacted a midwife at her GP practice asking if she could listen to the foetal heart. She was about 12 weeks pregnant at the time and was advised that it was too early to hear one, and that she needed to register with a GP in the area she was now living in.

4.2.4.On the 12/02/2016 the GP received a copy of the booking from a hospital outside of Bristol informing him that Aya's mother had attended a midwifery booking appointment. In discussion with Aya's mother she said she and Aya's father were living together in area outside of Bristol. She reported that she was not working at this time as she had moved to be with Aya's father who was working.

4.3.Narrative: During the period under review

4.3.1.On the 14/03/2016 Aya's mother attended NHS Trust 1 for a midwifery appointment following their move to Bristol. Aya's father also attended. Aya's mother was noted to be 24 weeks pregnant. She reported a history of depression and previous cannabis use (several years ago). She was not asked about domestic abuse as her partner was present. Aya's father told the midwife that he was smoking cannabis. Both were noted to have low mood and Aya's father was advised to attend his GP. Her ethnicity and family history/support was discussed. Aya's mother was identified as a low risk pregnancy. GP and health visitor were informed of the pregnancy in line with local protocol and a referral was made to the local Children's Centre. UNICEF leaflets regarding brain development were given to Aya's parents. Urine toxicology was to be checked at future contact and advice given regarding "Safe sleeping" in view of smoking/cannabis use.

4.3.2.On the 11/04/2016 Aya's mother and father were seen for a routine appointment with the community midwife. No problems were noted with her pregnancy. Urine toxicology was carried out to check for drug misuse. The result was negative. Aya's mother advised the midwife that she was seeing her GP later in the week for low mood. She was given information about National Childbirth Trust and Rockabye, both support services for pregnant women.

4.3.3.On the 14/04/2016 Aya's mother visited the GP with low mood, related to her current situation. She felt isolated and lonely due to her domestic situation and her move away from family and friends. She was advised of local groups and was to be seen again in four weeks.

4.3.4. Aya's mother attended a further five routine midwifery appointments, two of these appointments she attended alone. No concerns were identified with her physical health. On the 14/06/2016 the midwife completed a Family Life Events form identifying the family's social problems. Aya's mother reported that her emotional health was better than it had been. The midwife offered support and discussed possible referrals which were declined.

4.3.5. On the 21/06/2016 Aya's mother attended hospital in labour. Aya was born the next morning (22/06/2016). The birth was uncomplicated and routine care was provided. Aya's father was present at the birth. Aya and her mother stayed in hospital longer than normal due to Aya having an umbilical infection and needing antibiotics. During the time in hospital Aya's father visited apart from one day when he had diarrhoea and vomiting. On the 23/06/2016 and 26/06/2016 a midwife spoke to Aya's mother providing advice in relation to caring for Aya once discharged in line with NICE Guidance.

4.3.6. On the 26/06/2016 Aya and her mother were discharged from hospital. Routine advice was provided in relation to caring for a baby. It is not clear whether Aya's father was present when this advice was provided. No social concerns were noted and Aya's mother's emotional wellbeing was noted as "normal".

4.3.7. Aya and her mother were discharged from the midwifery service on the 10/07/2016, day eighteen. They received seven midwifery visits during that time. This was because Aya's weight gain was initially poor and her mother required additional support regarding her feeding and the management of thrush. During this period it was noted that Aya's mother was a single parent, with little support from Aya's father and that although she was isolated she was "emotionally stable".

4.3.8. Prior to the new-birth visit the health visitor contacted Aya's mother to arrange a suitable date and time, and liaised with the Children's Centre regarding the midwifery referral. At the new-birth visit on the 04/07/2016 the health visitor commenced the Family Health Needs Assessment (FHNA) in line with the locally agreed protocol. This was not completed at that visit (or subsequently) which was not best practice, but the social history and both parent's emotional wellbeing was assessed and advice provided. Aya's father was reported to be more supportive since Aya's birth. It is not clear whether he was present during the visit. A re-referral was made to the Children's Centre. The health visitor assessed the family as requiring Universal Services (a service provided to all children and families with under 5s) and arranged a follow up visit for the 15/07/2016 to complete the FHNA. Aya's mother was provided with information about the health visitor run postnatal support group which she attended regularly until Aya's death.

4.3.9. On the 15/07/2016 and the 22/07/2016 the health visitor visited Aya and her mother to provide feeding support. At a clinic visit on the 01/08/2016 (aged six weeks) Aya was weighed and noted to have showed good weight gain.

4.3.10. On the 01/08/2016 Aya's father went to his GP to see the stop smoking advisor.

4.3.11. On the 03/08/2016 Aya's mother had her postnatal check. Aya's father was reported to be helping and the relationship was "ok"

4.3.12. On the 17/08/2016 Aya had her 6-8 week developmental assessment. She was gaining weight well (25th centile) although Aya's mother reported that she was still having difficulty with breast feeding, which the health visitor was supporting her with.

4.3.13. On the 03/09/2016 Aya was reported to have fallen about one metre from a bouncy chair that was on the bed onto the floor. She had initially settled with a feed and a cuddle but then slept longer than normal so Aya's mother called the GP out of hours' service. Aya was examined. No injuries or bruising were noted and advice was given. Her GP was informed.

4.3.14. On the 26/10/2016 Aya's mother attended the Children's Centre and was given information about baby groups and One World Club which she attended in November and December 2016. She also attended routine health visiting clinic appointments during this time.

4.3.15. On the 07/11/2016 Aya's mother told the clinic health visitor that she would be moving soon as she had a new partner.

4.3.16. On the 19/12/2016 Aya attended clinic. The health visitor noted a very small bruise under Aya's chin, 'like the dot from a pen,' caused, she thought possibly, by the metal stud of the baby-grow. Aya's mother did not know the cause of the bruise.

4.3.17. On the 21/12/2016 Aya's father was seen by his GP for an unrelated problem.

4.3.18. On the 24/12/2016 Aya's father agreed to look after Aya whilst her mother and new boyfriend went out. At about 1 am on the 25/12/2016 Aya's father made a 999 call to the ambulance service saying that Aya was unresponsive. The paramedics and attending doctors attempted Advanced Life Support at the scene, and for a short period of time spontaneous respiration was achieved. Aya arrested again and was unable to be resuscitated. Following her being pronounced dead she was transferred by ambulance to hospital in line with the local Child Death Rapid Response protocol.

4.3.19. Aya's father was arrested at the scene and subsequently charged. He was convicted of murder on the 03/07/2017.

5. Analysis of Practice

5.1. NHS Trust 1 Maternity Services

5.1.1. Aya's mother self-referred to the hospital for her maternity care. She was not working at the time of booking having moved to be with Aya's father. She attended the booking clinic with him and was identified as a low risk pregnancy requiring routine care. She was not asked about domestic abuse as her partner was present which was appropriate. The booking assessment was extremely thorough with appropriate tests and referrals being made. Aya's father was included within this assessment and

advised to attend his GP for his low mood. The midwives continued to provide support during the antenatal period in relation to Aya's mother feeling unsupported and the unusual situation she was in. This showed a commitment to Aya's mother's emotional wellbeing as well as her physical health.

5.1.2. All first time parents are invited to antenatal classes in Bristol and Aya's parents were provided with information in relation to dates and times. Whilst it is not clear whether they attended (attendance lists for 2016 are not now available) Aya's mother did attend a one to one session with a midwife on the 29/05/2016 to discuss her birth-plan, however it is not clear whether Aya's father attended or whether there was any discussion in relation to his attitude or involvement in that plan. Antenatal classes in Bristol consists of 3 sessions:

- Early Birds covering antenatal specific topics
- Birth and Pain relief
- Caring for your baby and infant feeding

This process provides little opportunity for fathers to become involved and no opportunity for fathers to have the opportunity to discuss the changes that having a baby brings to a relationship or be advised about issues such as post-natal depression in fathers.

5.1.3. Prior to discharge Aya's mother was advised about common ailments that babies may experience. How she and her partner should respond to Aya and what cues they could pick up from her behaviour. It is not clear whether Aya's father was involved in this session, as this is not routinely recorded and current practice is to involve them if the father happens to be on the ward at the time. This can have the effect of excluding fathers/partners with them then not having the same level of information as their female partner and not being aware of common ailments and how to manage them.

5.1.4. The community midwives visited until day eighteen as Aya's mother was having difficulty breastfeeding and Aya was not gaining weight. This was appropriate practice and ensured Aya and her mother continued to be supported.

5.1.5. NHS Trust 1 Women & Children's Health 'Managing Domestic Abuse' guidelines state that:

"Routine enquiry should never be treated as a one off activity.

Enquiry at specified intervals increases the likelihood of a woman feeling safe enough to talk about her abuse. For example, women who develop a relationship with health professionals during a pregnancy might be more open to choosing to disclose abuse once the relationship is well established. All women must be asked about domestic abuse at least twice during their contact with midwifery service. The appropriate times are;

- At booking (or subsequent antenatal review visit)
- During postnatal period, prior to transfer of care to Health Visitor
- At any other time on cause or suspicion of domestic abuse"

Aya's mother was not asked about domestic abuse at the booking visit because her partner was present and she does not appear to have been asked at any other time during her pregnancy or following delivery. This was not in line with either local or national policy. Domestic abuse was not identified as a concern at the time of writing the review, however Aya's mother provided additional information prior to publication which relates to domestic abuse (financial) and an addendum in relation to this has been added.

5.2.Community Health CIC Health Visiting Service

5.2.1.The health visitor visited on the twelfth day post-delivery to carry out the New-birth visit. This visit is an opportunity to meet both parents and enables the health visitor to commence a holistic assessment of all family members. She can then identify the level of support that may be required in line with the Healthy Child Programme. It is also an opportunity to explain the health visitor role and service provided and how the health visitor will work in partnership with the family. The contact to arrange the new-birth visit is normally by telephone, and although described as a 'family' visit, can, unless reference is made specifically to the father, often be a contact with the mother and may not necessarily include the father. This can result in fathers' feeling excluded from the process and their needs not necessarily being met. In this case the health visitor was aware of the family situation, and that Aya's mother felt herself to be single parent. However Aya's father was a household member and going to be a part of Aya's life and it would have been good practice for his needs and role to have been included as part of the assessment. The new guidance (not implemented at this time) for the FHNA identifies the need for both parents to be present wherever possible and all significant family members to have their health needs assessed and documented. A pilot to implement electronic records is due to start in the autumn and it is important to ensure that the health needs of fathers and other household members are assessed and recorded within the electronic records being piloted.

5.2.2.In addition in this case the FHNA assessment was not completed which meant that the health visitor did not have all the information required to carry out an appropriate assessment. There is no evidence that she asked about domestic abuse or appears to have considered the impact of the situation on both parties or the level of support that might be required in the short term. Nor is there any evidence of discussion in relation to substance misuse. It is unclear when the 'Family Life Events' form was received by the HV as this was not date stamped, and the information in it did not appear to feature in the FHNA. This meant that the FHNA did not take this information into account and the opportunity to carry out a full assessment was lost. Standard practice is for the 'Family Life Events' form to be provided to HV with the Transfer of care letter at time of transfer from maternity to HV services.

5.2.3.The health visitor, in discussion with the independent reviewer, felt that she did consider the impact of a lack of family support for Aya which is why she followed up the midwives referrals to the Children's Centres. She also felt that this would support Aya's mother, who, having recently moved, had not had the opportunity to build up a

social network. She was providing the additional support in relation to the initial difficulties Aya's mother was having with breast feeding and was aware that Aya's mother was regularly attending the postnatal support group provided by the health visiting service. She therefore felt Universal Services were appropriate. However, had the FHNA been completed and Aya's father's health needs also assessed and analysed the family would have met the criteria for universal plus services, at least for the first few weeks following Aya's birth, providing the opportunity for some follow up discussion in relation to Aya's father, their relationship and family functioning.

5.2.4. In Bristol Universal services are made up of:

- Antenatal Contact: 28 weeks to delivery date through individual/group contact and covers transition to parenthood, maternal mental health and infant mental health
- Postnatal Contact: Birth – 6 weeks delivered face to face including a New-birth contact between 10 and 14 days; and covers; Transition to parenthood, maternal mental health, breastfeeding and Infant mental health
- 6-8 weeks delivered face to face and covers maternal mental health, breastfeeding, infant mental health, healthy/appropriate weaning
- 9-12 months delivered face to face and covers maternal mental health, healthy weight, healthy nutrition and physical activity, and infant mental health
- 2 – 2 ½ years delivered to individuals or via group session and covers health, emotional wellbeing, development and support to be ready for school, healthy weight, healthy nutrition and physical activity.

5.2.5. All children are allocated a named Health Visitor until the age of one, thereafter if receiving a Universal Service they become part of the corporate case load.

Where families need additional support a more intensive programme is provided; 'Universal Plus'. Children and families receiving a Universal Plus service will have, in addition to the Universal service, a package of care provided by the health visitor team to meet their identified need (i.e. mental health, behavioural concerns etc), which will have a clear action plan, timescales and outcomes.

5.2.6. At the clinic contact on the 19/12 /2016 Aya was noted by the health visitor covering the clinic to have a small bruise under her chin. She surmised that this may have been caused by the stud on Aya's baby-grow and did not follow the "Bruising and Injuries in non-mobile Babies" multi-agency guidance (Appendix 1). This recommends discussion with the community paediatrician and for the baby to be seen by a paediatrician within 24 hours, and a referral to First Response to occur so that agency checks can take place and any risks identified. Where the guidance is not adhered to it should be discussed with a paediatrician or safeguarding advisor and rationale for not doing so recorded in the records. This has been investigated internally, separately to this SCR and appropriately responded to. It is not clear how the bruise occurred or who was caring

for Aya at the time. It was however the second injury that Aya had (although the health visitor was not aware of this) and whilst a missed opportunity to refer to CSC, had they carried out welfare checks there was unlikely to have been any further action at that time.

5.3. Local Out of Hours GP Service

5.3.1. Aya's mother contacted the out of hours GP provision on the 03/09 /2016. Aya had fallen from her bouncy chair, which was on the bed, and on to the floor whilst her mother was looking after her. She appeared to have sustained no injuries and general advice was given to Aya's mother. She was examined down to her nappy and no injuries or tenderness was noted. It would have been good practice to examine her naked to ensure no bruising anywhere on her body. "Bruising and Injuries in non-mobile Babies" multi-agency guidance does not cover reported accidents/injuries where there are no physical injuries or bruising and therefore was not applicable in this case. There is no record to show that the GP assessing Aya considered safeguarding or the need for follow up in relation to accident prevention, in line with the current protocol. Had this happened the health visitor would have been informed, thus enabling follow up in relation to accident prevention.

6. Family Involvement in the Review

6.1. Aya's mother met with the Safeguarding Board Manager and Review Author on the 18th July 2017. The review process was explained to her and she was asked if she wanted to tell us a bit about Aya and also if there was anything she felt she wanted to share in relation to the care she had been provided with. Aya's mother felt unable to talk about Aya, but said she was a happy and well-loved baby. She shared the witness impact statement with the reviewer which spoke of how much Aya's death had affected her and what Aya meant to her.

6.2. Aya's mother felt that she had been provided with good care throughout her pregnancy, and the midwife provided advice and support when she talked about how unsupportive Aya's father was being during the pregnancy and how she was probably more unhappy than depressed. She was not offered relationship counselling but was not sure whether she would have found it useful. She appreciated the extra time in hospital and felt the midwifery support was really helpful as she had no experience of new-born babies. She said she was lonely moving to a new area but had looked at volunteering antenatally and had found a couple of friends on line. She had enjoyed some of the activities at the Children's Centre and met with other mums there. She said Aya's father loved Aya and was more supportive following her birth and she couldn't understand why he had done what he had.

7. Findings

7.1. What can we discover about a case that seems to have limited preceding risk factors and minimal agency involvement?

7.1.1. Whilst this was an unplanned pregnancy and an unusual situation there was no evidence of any underlying reason why Aya's father should become violent and kill his daughter. He was known to have had episodes of depression and previous drug misuse but since Aya's birth had appeared supportive towards Aya's mother and helped in her care. He had been seen by his GP shortly before Aya's death and no concerns had been identified.

7.1.2. From the evidence available at the time there were no warning signs missed.

7.2. What do professionals understand about the role of fathers in the antenatal and postnatal periods?

7.2.1. The Healthy Child Programme and government policy both encourage the active involvement of fathers both antenatally and postnatally. The Healthy Child Programme states that it should:

"begin early in pregnancy and to include: …

social support using group-based antenatal classes in community or healthcare settings that respond to the priorities of parents and cover:

the transition to parenthood (particularly for first-time parents); relationship issues and preparation for new roles and responsibilities; the parent–infant relationship; problem-solving skills (based on programmes such as Preparation for Parenting, First Steps in Parenting, One Plus One; the specific concerns of fathers, including advice about supporting their partner during pregnancy and labour, care of infants, emotional and practical preparation for fatherhood (particularly for first-time fathers); discussion on breastfeeding using interactive group work and/or peer support programmes; and standard health promotion".

Within Bristol fathers are invited to antenatal classes via the baby's mother. They do not get a specific invite to the classes and there are no specific antenatal sessions aimed at fathers commissioned. Fathers may not always be present when discharge advice is given to the mothers' and father's involvement is not routinely recorded.

7.2.2. The Healthy Child Programme also identifies the need for fathers to be involved in the health and developmental reviews:

"The contribution that fathers make to their children's development, health and wellbeing is important, but services do not do enough to recognise or support them. Research shows that a father's behaviour, beliefs and aspirations can profoundly influence the health and wellbeing of both mother and child in positive and negative ways.' Maternity and child health services are used to working mainly with mothers, and this has an impact on their ability to engage with fathers. Fathers should be

routinely invited to participate in child health reviews, and should have their needs assessed."

7.2.3. Whilst health visitor correspondence is addressed to both parents and there is no barrier to fathers being present at any contact there is no assertive approach to ensuring that fathers are actively involved in the process. This is consistent with findings from other Serious Case Reviews and national research.

7.2.4. Whilst there is no evidence that work with Aya's father specifically would have altered the situation there is currently no specific universal programme of work with fathers either in the antenatal or postnatal period.

8. Additional Learning

8.1. Domestic abuse

8.1.1. NHS Trust 1 identified a problem with compliance in this area in an audit carried out in 2016/17. Within the NHS Trust 1 maternity services 76% of mothers' were asked about domestic abuse during the antenatal period. Following this audit, Level 3 training 'Domestic Abuse and Pregnancy' was provided. This is provided on a rolling three year programme.

8.1.2. To assess current compliance and the impact of the training provided the audit will be repeated by the Trust in the 2017/2018 round of audits.

8.1.3. Additionally a business plan by NHS Trust 1 has been completed for a maternity Independent Domestic and Sexual Violence Advocate (IDSVA) and the outcome of the bid is awaited. This is expected to raise awareness and provide support to both the maternity staff and women in the antenatal and postnatal period. It will also support specific assessments for Domestic Abuse and support services for those women.

8.1.4. The health visiting service have been trained in Domestic Abuse awareness as part of L1 and 2 safeguarding training within their organization and the majority have also attended the Bristol SCB multi-agency training. Domestic abuse was also part of a rolling five year program of ongoing education and learning within the Trust and is the subject identified for 2018. Domestic abuse is considered as part of the FHNA and the new guidance being introduced makes this more explicit. The health visitors are trained in the use of the CAADA/ DASH assessment and expected to follow up and support victims of domestic abuse who come to their attention following police notification. Support for newly qualified health visitors in "asking difficult questions" effectively is provided as a part of preceptorship and all health visitors receive child protection supervision which includes cases where domestic abuse is a concern.

8.1.5. As a result of the concerns identified with the FHNA in this case an audit of FHNA completion and screening for domestic abuse will take place in quarter 3 of 2017/18 to establish the quality and completion of the assessments carried out.

9. Areas of Good Practice

9.1. Good practice has been identified within the analysis of practice. It includes the GP exploring the impact of home circumstances on Aya's mother when they saw her during her pregnancy; the good solid work by the midwives both prior to and following Aya's birth and the health visitor's support in relation to breast feeding.

9.2. In addition the ambulance service responded rapidly to the 999 call on the day of Aya's death and alerted the police in a timely manner.

10. Questions for the Board to consider

10.1. How does BSCB assure itself that the commissioning and delivery of health services are strengthened and resourced sufficiently to ensure the aspects of the "Healthy Child Programme" that relate to Fathers' Engagement is fully implemented?

10.2. How will BSCB assure itself that routine questioning about domestic abuse is embedded within all agencies working with women and children?

10.3. How will BSCB assure itself that the new guidance in carrying out FHNAs is fully implemented including assessment of household members and discussion about domestic abuse?

10.4. The current "Bruising and Injuries in non-mobile Babies" multi-agency guidance is about to be reviewed. Can BSCB be assured that the updated guidance will include within it that all members of the primary health care team who work with parents and children receive notification of any childhood injury? This would enable the health visiting service to assess whether any accident prevention or additional health visiting support is required.

10.5. Is the BSCB confident that the local Out of Hours GP service is effectively following the current protocol in relation to safeguarding and accident prevention?

11. Conclusion

11.1. Whilst there is always learning to be identified when carrying out a review, there was nothing identified in this review that would suggest that Aya's death could have been prevented and no warning signs that suggested that Aya was at risk. There is a finding, however, relating to the research question about engagement with fathers as well as findings related to the additional learning identified with questions/recommendations that the Board may wish to consider and implement.

12. Addendum

12.1. Once the report was completed and shared with Aya's mother she said, that in hindsight she recognised that Aya's father had some financial control over her in that she regularly lent him money for bills and travel to work. Aya's mother does not identify this as 'abusive' but feels that had she had more opportunity to explore the issue within her discussions with professionals she may have recognised the negative impact that this was

having on her. Aya's mother said that she felt that she had to give him money, even though he never repaid it, as she wanted his support with parenting Aya.

12.2. As this information was not known at the time of writing the report consideration of financial abuse was not an area explored in depth although the lack of discussion in relation to domestic abuse was identified as an area of learning. The Board will therefore need to assure itself that the domestic abuse training and the questioning of women regarding them experiencing any domestic abuse covers all aspects of abuse and does not concentrate solely on physical abuse.

12.3. Aya's father read the completed report before it was published. His feedback reinforced the importance of the findings relating to opportunities to engage with fathers and assess their needs. Aya's father said that he had misused drugs from adolescence and had experienced poor mental health following the death of his parents and grandparent. He said that the only time he had sought help for this had been some years before Aya was born when he was prescribed antidepressants by his GP. Aya's father reported that he did not take this medication. Aya's father said his drug use reduced significantly after Aya was born. He said that he wanted to be involved in Aya's life but that he could not attend many of the appointments because they were held while he was at work. He said that men werebad for 'burying things' and not addressing issues and that he regretted that he never sought help from professionals. He said it may have been helpful for him to have had discussions with professionals about his mental health and drug use after Aya was born but that he never had that opportunity. Aya's father said he is unable to explain what triggered his violence towards Aya on the evening that she died as he loved his daughter and had regularly cared for her previously.