Serious Case Review
Baby M

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INDEPENDENT REVIEWER

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INTRODUCTION

1 BACKGROUND - The Child's Journey

1.1 In her second interim report entitled 'The Child's Journey'[1], Professor Munro identified the importance of analysis of the 'child's journey' through services and for families to receive effective help at the earliest point for problems arising from family and social circumstances. In the case of Baby M that journey started from the date that agencies were first informed that his Mother was pregnant on the 10/01/2014 until the date of the Emergency Protection Order on the 10/12/2014.

1.2 Baby M, a 16 week old baby, was admitted to A&E at 3.45am on the 27th November 2014 following an incident during which his Father was alleged to have fallen whilst holding him after tripping over his trousers. The Father stated that he had fallen, landing on Baby M. Baby M was admitted to hospital and following medical investigations he was discovered to have a linear fracture to the left parietal of his skull. This injury was indicative of a single trauma. In addition he had multiple bruises and a torn frenulum. The explanation provided by the Father was accepted by hospital staff and Baby M was discharged home initially staying with his maternal grandmother then returning to the care of his parents on the 4th December 2014.

1.3 Baby M was readmitted to hospital in the early hours of the 5th December 2014 following a call to the emergency services as he was floppy and unresponsive. Baby M was discovered to have numerous bruises and rib fractures of different ages in addition to the skull fracture, bruising and torn frenulum of his previous admission. A Finding of Fact hearing during subsequent Care Proceedings found that the rib fractures had occurred during two separate incidents with the first occasion prior to Baby M's first admission to hospital with the skull fracture.

[1] The Child's Journey- 2nd Interim report - https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/206993/DFE-00010-2011.pdf.

2 PUBLICATION

2.1 In line with publication requirements for Serious Case Reviews this report has been anonymised to protect the identity of the child involved, he shall be known as Baby M and his date of birth will not be included in the report.

REASON FOR THIS SERIOUS CASE REVIEW

3.1 Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake reviews of serious cases in accordance with procedures as set out in 'Working Together to Safeguard Children' (HM Government 2015).

3.2 A serious case is one where:

- abuse or neglect of a child is known or suspected; and
- Either the child has died or the child has been seriously harmed.

3.3 In these circumstances the LSCB should conduct a Serious Case Review (SCR) into the involvement that organisations and professionals had with that child and their family.

3.4 Working Together 2015 says SCRs should:

- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- recommend actions which result in lasting improvements to services which safeguard and promote the welfare of children and help protect them from harm; and
- be transparent about the issues arising from individual cases and the actions which organisations are taking in response to them, including sharing the final reports of SCRs with the public.

3.5 The Buckinghamshire Safeguarding Children Board (BSCB) Chair decided on 17th December 2014 to hold a Serious Case Review because the child in this case had suffered serious injuries and abuse was suspected.

3 SPECIFIC TERMS OF REFERENCE

Assessments

4.1 To establish what assessments were undertaken of the Father and Mother, and the quality of those assessments. This should include assessments relating to mental health and substance misuse.

4.2 To establish what risk factors were identified in relation to the baby pre-birth, and whether appropriate procedures were followed.

4.3 To establish what risk factors and needs were identified in relation to the baby after the birth.

4.4 To establish to what extent the parenting capacity and the needs of the parents were considered and addressed.

4.5 To establish if plans were implemented for the Mother, Father or baby, and to what extent the plans addressed any risk factors identified in the assessments.

4.6 To establish whether practitioners understood the thresholds for intervention - from Early Help through to Child Protection.

Service provision

4.7 To establish if there were factors which enhanced or impeded working relationships with the parents.

4.8 To establish if there were any capacity issues within agencies which impacted on the quality of services provided.

4.9 To take account of whether lessons learned from relevant previous Serious Case Reviews have been embedded.

Professional practice

4.10 To establish if the staff involved had the skills, knowledge and experience to address the issues within the family.

4.11 To establish if the diversity needs within the family were identified and addressed.

4.12 To establish if staff within agencies co-operated to achieve the best outcomes for the child.

Management oversight

4.13 To establish if agencies shared information appropriately and involved other professionals or agencies as necessary, including adult services.

4.14 To establish to what extent individual agency and multi-agency policies were adhered to and comment on the adequacy of those policies.

4.15 To establish if staff directly involved had appropriate supervision and managerial guidance.

Other

4.16 Individual Management Review Report writers to identify any additional issues for consideration by the Overview Report writer, including those which fall outside of the active period of the review.

5 TIMESCALE

5.1 The timescale for the active period of the review is from the 21/01/2014 to the date of the Emergency Protection Order for Baby M on the 10/12/2014.

6 FAMILY INVOLVEMENT

6. 1 It is important that family members are involved in the review process and that they have the opportunity to understand why a Serious Case Review is being conducted. Family members should be consulted and given the opportunity to provide information about their contact with professionals and the quality of services that have been provided.

6. 2 It has not been possible to interview Baby M's parents due to ongoing criminal investigations. The family were notified that a Serious Case Review would be taking place.

7 PARALLEL PROCESSES

7. 1 During the process of this review there have been ongoing criminal investigations and care proceedings in respect of Baby M. Care proceedings have now concluded and Baby M is the subject of a Placement Order[2]. Expert medical reports and those of the Finding of Fact hearing relating to those proceedings have been released by the court to be considered within this review.

8 INDEPENDENT REVIEWER AND PANEL

8.1 An Independent Reviewer, Sharon Hawkins, was commissioned to undertake this Serious Case Review. Sharon qualified as a Social Worker in 1994 and after 18 years of being employed in Local Authorities in the North West of England she became an Independent Safeguarding Consultant in 2012. Sharon has 21 years of experience of both social work and management at various levels in frontline children's services. She is experienced in completing Serious Case Reviews and reflective learning reviews and completed the national training programme for Serious Case Review authors in 2013.

[2] A Placement Order, made under section 21 of the Adoption and Children Act 2002, gives authority to a local authority to place a child with prospective adopters. It can only be made in relation to a child who is the subject of a Care Order or where the Threshold Criteria for a Care Order are satisfied or where there is no parent or guardian.

8.2 Short reports and Individual Management Reviews were requested from the following agencies:

Buckinghamshire County Council's Children's Social Care Service	IMR
Youth Offending Service	IMR
Wycombe District Council	IMR
Buckinghamshire Healthcare NHS Trust - Maternity	IMR
Buckinghamshire Healthcare NHS Trust - Acute Services	IMR
Buckinghamshire Healthcare NHS Trust - Health Visitors	IMR
Thames Valley Police	IMR
General Practitioners (GPs)	IMR
Oakhill Secure Training Centre	Short report
Ambulance Service	Short report
Buckinghamshire County Council's Adult & Family Wellbeing Service	Short report
Buckinghamshire Law Plus	Short Report
Oxford Health – CAMHS (Children & Adolescent Mental Health Services)	Short report
CAFCASS (Children and Family Court Advisory and Support Service)	Short Report
Organisation providing support for young people aged 16 – 18 yrs	Short report
Special Needs School	Short Report
Organisation providing support for young homeless people aged 16 – 20 yrs)	Short Report
Connexions	Short Report
Addaction	Short Report
Young Addaction	Short Report

8.3 The members of the Serious Case Review panel for Baby M comprised of senior managers from the key statutory agencies who have had no direct involvement with the case. The panel members identified authors within their own agencies to complete the Individual Management Review reports. The role of the panel was to actively manage the review and to provide oversight and scrutiny through all aspects of the process. An Independent Chair, Malcolm Ross, was appointed to chair the Serious Case Review Panel.

8.4 The following agencies were represented on the panel alongside the Buckinghamshire Safeguarding Children Board:

- Buckinghamshire Healthcare NHS Trust
- Youth Offending Service
- Buckinghamshire County Council Social Care
- Thames Valley Police
- Buckinghamshire Clinical Commissioning Groups

9 PROCESS AND METHODOLOGY

9.1 On the 17/02/2015, the Serious Case Review Panel met to consider the timeframe and terms of reference for the SCR.

9.2 Working Together 2015[3] requires serious case reviews to be conducted in such a way which;

- recognises the complex circumstances in which professionals work together to safeguard children

[3]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf

- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight
- is transparent about the way data is collected and analysed
- make use of relevant research and case evidence to inform the findings.

9.3 The Serious Case Review Panel in this case requested that agencies completed chronologies and Individual Management Reviews of their involvement with Baby M and his parents. A composite chronology was completed and made available to the Independent Reviewer.

10 ETHNICITY, DIVERSITY AND CULTURAL ISSUES

10.1 Buckinghamshire is a relatively affluent county with good transport links to London. It has shown increasing population growth rates with increases of 5.7% between 2001 and 2011, a population rise from 479,024 to 506,550. Reflecting the national picture there has been a large increase in older people age 65+ at 21%. However, there has also been an increase in population for children and young people (age 0-19) and adults (age 20-64) of 3.3% and 2.9% respectively. The future population predictions have indicated that growth will continue to increase to 547,022 by 2021[4].

10.2 Buckinghamshire has a predominately White British population; the second largest ethnic group is people from Asian British heritage[5].

10.3 Baby M and his parents are of White British heritage and identified with the local culture where they lived.

10.4 Both parents had learning disabilities and attended special needs schools. Very few agencies recorded any information in respect of disability.

[4] http://www.buckscc.gov.uk/media/2906128/Buckinghamshire-Population-Projections-Dec2014-.pdf

[5] https://docs.google.com/spreadsheets/d/1yc8W1SiCbWd9V4I9KmTlY_Rk_qullL828Qxbsvth93w/edit?hl=en&pli=1#gid=0

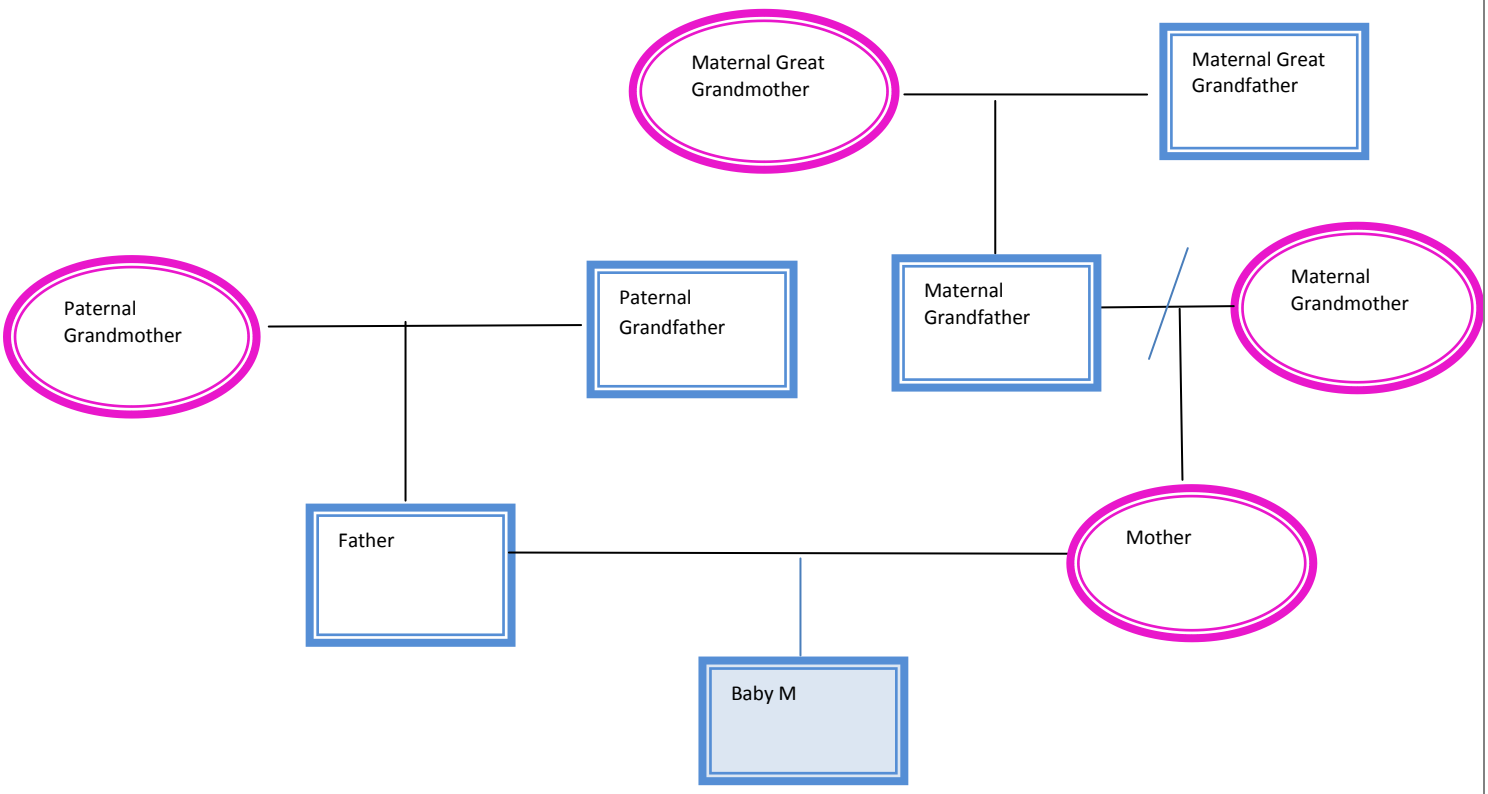
10.5 The Father of Baby M is a former Looked After Child and received After Care Services.

11 BACKGROUND NARRATIVE AS KNOWN TO AGENCIES

Family Composition

Relationship	Acronym
Subject Child	**Baby M**
Mother	**Baby M's Mother**
Father	**Baby M's Father**
Maternal Grandmother to Subject Child	**MGM**
Maternal Grandfather to Subject Child	**MGF**
Paternal Grandmother to Subject Child	**PGM**
Paternal Grandfather to Subject Child	**PGF**
Maternal Great Grandmother to Subject Child	**MGGM**
Maternal Great Grandfather to Subject Child	**MGGF**

Genogram



Mother

11.1 There is a long history of service involvement with the Mother of Baby M, dating back to her early childhood. The first recorded referral in respect of Baby M's Mother was in August 2004 when she was aged 8 years. Prior to this referral the maternal family had been known to Children's Services and Baby M's Mother had been subject to a child protection plan in 2004 along with her siblings. Information identifies that she grew up in a household where there was a considerable level of domestic abuse and concerns regarding compromised parenting.

11.2 Concerns continued throughout Baby M's Mother's childhood and at aged 15 she was referred to CAMHS due to concerns regarding self-harming behaviours. Baby M's Mother had special needs and attended a Special Needs School as a boarding pupil from Monday to Friday, spending weekends at home with her Mother

and siblings. She was one of the more able students at the school but her behavioural difficulties held her back. As well as Baby M's Mother attending a special needs school her Mother, the MGM, was also a pupil at the same school when she was younger. Agencies continued to have concerns about the parenting Baby M's Mother and her siblings received during this period, including a joint Section 47 investigation being carried out following allegations that the maternal grandmother had punched Baby M's Mother's brother in the stomach.

11.3 Baby M's Mother was seen by CAMHS in January 2012 following an overdose. When she was 17 the relationship between her and her Mother deteriorated and Baby M's Mother left the family home initially staying with an aunt before this broke down; she was referred to Connexions due to homelessness risk. In 2013 she was part of an enquiry into Sexual Exploitation. Baby M's Mother was one of a number of female victims in this investigation. The offender pleaded guilty to a number of the charges, but the one relating to Baby M's Mother was not proceeded with. It has not been clear throughout the review as to why this happened and the Police IMR author has been unable to identify a reason other than Baby M's Mother was living in supported lodgings at this time and had declined to cooperate with any Police investigations. The case was closed to Children's Services on 18th Nov 2013 as Baby M's Mother was no longer deemed in need of services.

Father

11.4 Baby M's Father first became known to Children's Services in July 2008 when he was 12 years of age. The referral was made by the probation officer who had been working with his Mother due to benefit fraud. During meetings with the Probation Officer she had disclosed that Baby M's Father had been violent towards her, she also disclosed that her relationship with his Father (PGF) had been one of regular violence resulting in him leaving the family home when Baby M's Father was aged 3.

11.5 A further referral was received in 2011 by Children's Social Care when Baby M's Father was aged 16; concerns were in respect of him regularly featuring as a

missing person. His Mother said she was struggling to cope with him and requested that he was accommodated under S20[6].

11.6 Baby M's Father had a diagnosis of ADHD and had been prescribed medication for this. He attended a school for children with emotional and behavioural difficulties. He had involvement from CAMHS between May 2011 and January 2012 and again in November 2013 to December 2013.

11.7 In September 2012 Baby M's Father was remanded into Local Authority care following his involvement in an attempted robbery[7]. He was placed at home with his Mother and received services as a Looked after Child.

11.8 Baby M's Father was known to the Youth Offending Team; he had a history of criminal behaviour including armed robbery for which he received a 18 month Detention and Training Order of which he served 7 months in custody and the remainder in the community on licence. He was subject to MAPPA[8] and classified as a category 2[9] offender. He was released from Custody in January 2013 and had been an exemplary prisoner. Risk assessments of him indicated he was a medium risk of serious harm to others.

11.9 In November 2013 Baby M's Father was detained by the Police under section 136 of the Mental Health Act following an attempt to hang himself in the family home. He ran away and was found in the woods by Police with a scarf, cable tie and

[6] Section 20 of the Children Act 1989 relates to the Local Authority's duty to provide accommodation for any child in their area who needs somewhere to live.
[7] Attempted Robbery' and 'Possession of a Firearm or Imitation Firearm at the time of Committing or being Arrested for an Offence'
[8] Multi-agency public protection arrangements are in place to ensure the successful management of violent and sexual offenders. The Criminal Justice Act 2003 ("CJA 2003") provides for the establishment of Multi-Agency Public Protection Arrangements ("MAPPA") in each of the 42 criminal justice areas in England and Wales. These are designed to protect the public, including previous victims of crime, from serious harm by sexual and violent offenders. They require the local criminal justice agencies and other bodies dealing with offenders to work together in partnership in dealing with these offenders.
[9] People convicted of a violent or other sexual offence (even if nobody was actually hurt), who are not registerable sexual offenders, with a 12 month or more prison sentence or hospital order, for a schedule 15 offence (Category 2).

a penknife. He was detained and taken to a place of safety and following assessment he was discharged to the care of his aunt.

11.10 Between 2008 and 2014 Baby M's Father was reported as a missing person on 51 occasions, as a victim and suspect in robberies, reported to have assaulted a female with a bat, to have himself been a victim of assault and involved in domestic incidents.

11.11 Information known to agencies in respect of Baby M's Father included him being a young man with learning difficulties who displayed aggressive and violent behaviour, was involved in risky behaviour including going missing and staying out overnight, cannabis misuse and offending behaviour involving violence.

12 CHRONOLOGY OF SIGNIFICANT EVENTS IDENTIFIED IN THE INDIVIDUAL IMRs

12.1 This section is designed to summarise the key relevant information that was known to the agencies and professionals involved with the parents, who were both very young first time parents with known learning difficulties, and the circumstances of Baby M both pre and post birth. The Review is concerned with Baby M and the events which may have impacted on the adults caring for him.

Pre-birth Period

12.2 On the 21/01/2014 the Community Midwife had her first contact with Baby M's Mother at the GP surgery; she was seven and half weeks pregnant and living in supported accommodation. The estimated date of delivery was in late summer of 2014. The Father of Baby M was not recorded as being present at the booking appointment but was identified as her emergency contact.

12.3 She disclosed a history of depression, learning difficulties, family problems and occasional cannabis misuse. She advised the Midwife that the baby's Father was a care leaver, had ADHD and was a daily cannabis user. The Midwife undertook the routine enquiry for domestic abuse but no disclosure was made.

12.4 The Midwife had access to the Mother's GP notes and had noted the previous history of self-harm. Following the booking appointment a referral was made to the Teenage Pregnancy Liaison Midwife. The issues identified in the referral form were in respect of accommodation; however it was noted about the previous self-harm, cannabis and mental health issues.

12.5 On the 08/02/2014 Baby M's Father was reported as missing by a member of staff at his supported accommodation. The member of staff telephoned Thames Valley Police and advised them that this had not happened before. Baby M's Father had told staff about a 'punch up' he had been involved in the night before following accusations that his girlfriend was pregnant with another man's child. Baby M's Father's girlfriend is recorded as being less than three months pregnant. The member of staff gave a list of Father's vulnerabilities: these included having a small build like a ten year old, having ADHD, alcohol/ drug misuse including legal highs and self-harm.

12.6 The member of staff also advised the Police that Baby M's Father liked to fight and might carry a weapon to make up for his small size. He had telephoned his Mother (PGM) who lived locally but she had told him not to visit her as she was poorly. The member of staff thought that he was out on his bike somewhere possibly trying to seek retribution for the events of the night before. He turned up later the following day but would not say where he had been or with whom.

12.7 Baby M's Father appeared in court on the 21/2/2014 for Possession of Cannabis and he received a six month Referral Order. An assessment took place by the Youth Offending Service which risk assessed him as medium risk of re-offending, high risk of vulnerability and low risk of serious harm to others. This resulted in a Vulnerability Management Plan being put in place. He was re-referred to CAMHS by the Youth Offending Service following email and telephone discussions between the two services.

12.8 During this same time period Baby M's Father was presenting with increasingly difficult behaviours at his supportive lodgings placement, he was failing to engage

with staff and not adhering to the house rules, he also had fallen out with other young people over money.

12.9 The Community Midwife met with the Children in Care Social Worker at her request to discuss Baby M's Father who had been a Looked After Child. The Children in Care Social Worker advised the Community Midwife that she would liaise with the social work team once initial referral had been received from the Community Midwife in respect of Baby M.

12.10 An incident occurred outside of the Connexions building between Baby M's Father and another young person on the 19/03/2014, which resulted in Baby M's Father being assaulted. This was as a result of the other young person believing Baby M's Father was responsible for getting the assailant's cousin (Baby M's Mother) pregnant.

12.11 On the 20/03/2014 a referral was received by Children's Social Care, the referrer was the Community Midwife and the referral was received by the First Response Team. The referral identified that Baby M's Mother was 16 weeks pregnant and living in temporary accommodation. She had engaged in ante-natal support and was open to support from other agencies. The referrer identified that Baby M's Mother required support around her housing need and did not identify any other vulnerabilities. The same day the Children in Care Social Worker for Baby M's Father was contacted by his placement due to concerns that he had been smoking cannabis on site, had been constantly presenting with disruptive behaviour and had taken another vulnerable resident off site and persuaded him to take MKAT[10].

12.12 A Child and Family Assessment was commenced on the 20/03/2014 following on from the referral from the Community Midwife. Baby M's Mother also contacted the First Response Team on the 27/03/2014 to inform them she was pregnant and that she needed support with accommodation. The records for unborn Baby M commenced this day.

[10] Mephadrone, also known as 4-methylmethcathinone is a synthetic stimulant drug of the amphetamine and cathinone classes. Slang names include M.CAT, White Magic and meow meow.

12.13 As well as referring Baby M's Mother to Children's Social Care the Community Midwife also made a referral to the Family Nurse Partnership[11]. The Family Nurse Partnership is a national programme which is designed to improve the health, wellbeing and capacity of young first time parents. The programme offers support for up to two years to first time mothers under the age of 19. Support is available through the stages of pregnancy until a child is two years of age. The evidence base around Family Nurse Partnership has shown that the programme provides positive outcomes in the short and long-term. The service has limited capacity and once practitioners are at caseload capacity there is limited opportunity for new families to be picked up. This was the situation with Baby M's Mother; at the point of referral there was no capacity and she did not receive a service.

12.14 The assessment for the unborn child continued and on the 23/04/2014 as part of the process the First Response Social Worker spoke to the Community Midwife and asked about her view and prognosis of Baby M's Mother as a mother; he also spoke to Baby M's Father's Children in Care Social Worker. Following the discussion with the Children In Care Social Worker it was noted in the case record for Baby M by the First Response Social Worker that: "*we have a discussion. He (Baby M's Father) does not present with any concerns as a potential Father in regards to safeguarding. By nature of his status he will be vulnerable".* On the basis of this recording it appears to the IMR author that the First Response Social Worker accepted that Baby M's Father posed no risk to the unborn child.

12.15 Between March and June 2014 concerns continued to be raised from the placement provider for Baby M's Father to his Children in Care Social Worker in the Children in Care Unit. The concerns involved unauthorised absences, drug use and behaviour toward other tenants. On the 02/06/2014 the Children in Care Social Worker visited the placement due to continued concerns regarding Baby M's Father taking food and money off other young people and being critical about the state of the bathroom. When challenged about this behaviour in the unit he had smashed a

[11] Fnp.nhs.uk

table to pieces. The Children In Care Social Worker shared this information with the First Response Team as she was concerned about the incident and the risks Baby M's Father could pose to Baby M's Mother and the unborn Baby M. Baby M's Father expressed unhappiness at this and agreed to stay within the boundaries set by the placement.

12.16 According to the Thames Valley Police IMR, during the time period from confirmation of the pregnancy to Baby M's birth there were four separate occasions when Thames Valley Police had receipt of information and intelligence which should have been shared with Children's Social Care. The Police IMR author noted that with the knowledge held in respect '*of Father's previous violent offending behaviour, cannabis use, and recent suicide attempt, news that he was going to become a Father would be of interest to Children's Social Care and would have met the threshold for information sharing'*[12].

12.17 On the 12/5/2014 a referral was made by the First Response Social Worker to Family Nurse Partnership (FNP). He was advised that Baby M's Mother had already been referred in by the Community Midwife but that there was no capacity to take the referral at this time. During May the First Response Social Worker made a number of referrals for Baby M's Mother regarding accommodation needs, Adult Services for a capacity assessment due to her '*additional needs'* and also referred the family to the Junior Catch Team[13] for a pre-birth assessment. He advised the manager of Junior Catch that although the Child and Family assessment was still ongoing it was likely that the outcome would be for the unborn baby to receive services as a Child In Need. The team manager at Junior Catch advised the First Response Social Worker that she would be unable to allocate immediately due to service pressures and demand.

[12] The threshold is met when someone believes a child may be suffering or at risk of suffering significant harm. (NPIA Investigating Child Abuse 2009, 1.9.1)

[13] Junior CATCH focuses on supporting the units in providing an intensive, flexible service for children and families, including a rapid response service. The Junior CATCH Teams will consist of staff with a range of skills suitable for working with families who are in crisis or where chronic problems have become acute.

12.18 On the 18/06/2014 Baby M's Father was seen by CAMHS for his appointment following on from the referral from the Youth Offending Service. He advised CAMHS that he was feeling well emotionally and mentally and did not require a service from them. He informed the Psychologist that he was going to be a Father. A letter was sent to the Youth Offending Service from CAMHS advising that he was not in need of services at this point.

12.19 As a young person in care Baby M's Father had regular statutory visits[14] undertaken by the Children in Care Social Worker to his supported lodgings. During a statutory visit his key worker raised concerns with the Children in Care Social Worker regarding his anger and the high risk this may pose for a baby. The Children in Care Social Worker agreed she would be informing the unborn Baby M's Social Worker of this information. Baby M's Father was unhappy about this being shared but the Children In Care Social Worker explained to him that she was very concerned for his girlfriend's safety and more so for the baby's safety. He agreed to comply with the placement boundaries.

12.20 During June Baby M's Father spent less and less time in the placement, often staying with Baby M's Mother. There was regular email communication between the Social Worker for Baby M, the Children in Care Social Worker and the Youth Offending worker. During these email exchanges reference is made to the anger issues displayed by Baby M's Father and also his use of drugs including Cannabis and MKAT. There is also reference to his diagnosis of ADHD.

- Baby M's Father was discussed at the Risk Management and Vulnerability Panel[15] in June. The Children in Care Social Worker attended the panel and discussed the concerns she had in respect of his behaviour and drug misuse.

[14] www.proceduresonline.com/buckinghamshire.chservices/chapters/p_sw_visits.html

[15] RMVP's are held on all young people who are assessed as high or very high risk of serious harm to others or vulnerability. This ensures that the Case Manager is given support in devising and delivering interventions for high risk cases and that these are subject to relevant management team support and scrutiny. This is a formal meeting chaired by an Operational Manager. Relevant partner agencies attend which ensures the risk is managed in a co-ordinated way.

CAMHS were contacted following the panel to confirm whether or not he was still being prescribed medication for his ADHD. His Risk Management Plan was updated following this panel and his risk was assessed as Medium risk of Serious Harm to others.

It is noted in the Risk of Serious Harm ASSET[16] that *"if this behaviour continues in front of a child this could cause harm in terms of emotional and unintentional harm as it would be intimidating and feeling of security and safety would be affected.[17]"*

12.21 The YOS worker shared by e-mail details of a session with Baby M's Father on 01/07/2014 in which she discussed anger management issues with him. In this session he told her that the staff at the placement "lie" about his anger issues. He denied that he had broken the table alleging that this was already broken. He described dealing with anger towards Baby M's Mother by walking away and that a baby would be a different type of stress.

12.22 On 01/07/2014 the Junior Catch Social Worker emailed Baby M's allocated Child In Need (CIN) Social Worker giving a summary of her background reading and concerns about the family situation and she requested a network meeting in 3 weeks. It is unclear to the reviewer why this timeframe was suggested considering the delay in the pre-birth assessment commencing and the birth being now only a couple of months away. The purpose of the network meeting would be to plan the work with Junior Catch, and the allocated Social Worker from the CIN unit would lead this planning process and bring together the relevant agencies to share information. The Junior Catch Social Worker also asks in the e-mail, *"Is this case going to CP?"* There is no indication in the records throughout the period of the review that child protection procedures were considered by either the First Response Social Worker or the CIN Social Worker.

[16] ASSET is a structured assessment tool that is used by Youth Offending Teams(YOTs) in England and Wales with young people who come into contact with the criminal justice system. It aims to look at the young person's offence or offences and identify a multitude of factors or circumstances – ranging from lack of educational attainment to mental health problems – which may have contributed to such behaviour.
[17] YOS IMR

12.23 Concerns regarding anti-social behaviour in respect of Baby M's Father continued in July and these were discussed during a case management discussion in the Child In Need Unit on the 27/07/2014. The Children's Social Care IMR identified that both parents are recorded as having been difficult to get hold of during this time. The planned network meeting took place on the 01/08/2014 and six sessions were planned with the parents for the pre-birth assessment.

12.24 Three of the planned pre-birth sessions took place before Baby M was born in August 2014. There is evidence in one of the sessions of Baby M's Father controlling the agenda regarding what needed to be covered. He advised the Junior Catch Social Worker that he had experience of babies due to looking after an electronic one previously for 24 hours. He stated that he had managed well, therefore this did not need covering in the session. Baby M's Mother also identified that she knew how to care for a baby due to caring for her sister's child. Baby M's Father identified that drug issues did not apply as he no longer used these and he had also not been involved in any violent or aggressive behaviour therefore the worker did not need to assess this area.

12.25 During this pre-birth period, as well as the work which arose in respect of Baby M, Baby M's Father continued to receive services as a young person who had been in care and was eligible for after care services. He therefore had an allocated Social Worker, from the Children in Care unit. This Social Worker continued working with him until the 11/8/2014 when he was allocated a Personal Advisor from the After Care Service.

Post Birth Period

12.26 Baby M was born in August at 37 weeks gestation in hospital. Baby M's Mother was accompanied by her grandparents when she presented and labour and delivery progressed normally. Baby M was born in good condition weighing 2720g.

12.27 Mother and baby were discharged home and visits continued by the Community Midwife until the 26/08/2014 when the baby was discharged into the care of the Heath Visitor. The Community Midwife did not have any clinical concerns about

either Mother or baby; any clinical concerns would have resulted in a delayed discharge.

12.28 Baby M's arrival did not trigger any contact between the Midwifery Service and Children's Social Care. The first notification that Baby M was born came after Baby M's Mother attended a planned pre-birth assessment session at Junior Catch on 22nd August and arrived with Baby M. Social Care records indicate that the baby was born prematurely but the birth date is within the expected range of the possible delivery date of a full term baby. Baby M's Mother advised the Junior Catch Social Worker that she was living with her Mother (MGM) with Baby M and that she was due to move to her own flat the following week.

12.29 Baby M was seen on a regular basis from his birth onwards by a range of agencies and throughout September 2014 home visits and observations of him in the care of both his parents were undertaken by the Health Visitor and the CIN Social Worker for Baby M. The Health Visitor noted Father feeding and cuddling Baby M during one of her visits. During the CIN Social Worker's visit the parents advised that Baby M's Father was visiting daily and staying over two nights each week. Baby M's Mother described him as a good support and helpful with the baby.

12.30 On the 22/09/2014 the emergency services were contacted by a female, who was suspected to be Baby M's Mother, via the 999 service. The female mentioned her boyfriend to the operator and then the phone was disconnected before the call was connected to Thames Valley Police. A further call was received by Thames Valley Police indicating that a dispute had been heard outside the flat occupied by Baby M's Mother. The caller alleged that Baby M's Mother had thrown a scooter down the stairs outside of the flat and that smashing was also heard. The caller knew that there was a young baby (Baby M) at the address and that the Father had left the property. When the Police attended, Baby M's Mother advised them she had "*kicked Father out*" as he was lazy and he had ADHD and didn't take medication. Baby M was seen by officers who stated he 'seemed happy'[18]. Baby M's Mother

[18] TVP IMR Section 4.156

stated that he had been lying on the bed during the domestic incident. Children's Social Care and the Health Visitor were notified about this incident; the Health Visitor visited the following week and discussed the domestic abuse incident and the impact this could have on Baby M.

12.31 There is no indication that Children's Social Care responded to the domestic abuse notification or reassessed any risks to Baby M on the basis of this information. Universal health services continued to be offered during this time; Baby M was seen by both the Health Visitor and the GP and was seen to be developing well.

12.32 Child In Need (CIN) meetings did not take place despite Baby M being subject to a CIN plan and this being a recommendation in supervision notes for the CIN Social Worker in both September and October 2014.

12.33 A unit case management meeting on 21/11/2014 describes the situation positively regarding the family and suggests that initial concerns had been allayed by how well Baby M is developing and meeting his milestones. The flat was described as clean and furnished and Baby M's Father was staying over a few nights per week with a view to moving into his own flat. Despite being referred to a children's centre the parents had not accessed any services.

First Hospital Admission 27/11/2014

12.34 Baby M was admitted to the hospital Accident & Emergency department on 27th November, 2014 at 03:45 am. He was brought to the hospital by his Mother and Father following a fall. [19]Baby M was seen in the Paediatric Decision Unit (PDU), and an assessment was carried out by the Triage Nurse at 03:47. The Triage Nurse took a history regarding the incident from the parents. Father reported to the nurse that he had been giving the night feed, and whilst holding Baby M, he tripped and fell onto Baby M. The parents reported that Baby M had not lost consciousness and had not vomited following the fall. During this initial assessment, the Triage Nurse noted there were marks around Baby M's face, particularly around his nose and

[19] BHT Acute Services IMR

mouth, as well as bruising under Baby M's right eye. Parents informed the nurse that this had been caused by a scratch from the previous day.

12.35 Baby M was seen by two doctors in A&E and reviewed by the Consultant Paediatrician. The Father maintained his story of tripping over his trousers and falling with the baby in his arms and he was consistent in the telling of this to all three doctors and to the Triage Nurse. The hospital completed a referral form to Children's Social Care but this was sent for information only and not because they were requesting a service. During the telling of the sequence of events the parents did give two different versions of how they got to hospital. Initially they stated that they had called 111 immediately after the incident and an ambulance attended and took them to hospital. Later when Baby M was reassessed in PDU by the A&E doctor the parents informed him that they tried to call for an ambulance, but were advised to get their own transport, so Baby M's Father called his Father (PGF) who provided them with transport to the hospital.

12.36 The assessments undertaken in A&E included social and medical history and a genogram being completed. It was during this process that the A&E Doctor discovered that Mother had a Social Worker and that Father had been in care. An examination of Baby M was completed, and it was noted that Baby M had long dirty nails and a range of marks and bruises. The A&E Doctor completed a body map, documenting all of Baby M's injuries and discussed the case with the on call Paediatric Consultant. Following this discussion it was agreed that the case would be discussed with Children's Social Care and the Health Visitor during daytime hours and that the child protection pro forma[20] was not necessary. The agreed plan also stated that a CT scan and ophthalmology review were required: depending on the outcome of these two investigations, a skeletal survey may be completed. The A&E Doctor was unable to reach the radiologist despite ringing and bleeping. At 07:50, Baby M was reviewed by a Paediatric Consultant. The Paediatric Consultant went over the history of the incident with the parents, and in the consultant's opinion

[20] The Buckinghamshire Healthcare NHS Trust Child Protection pro forma was introduced in August 2007. The proforma was introduced as a link document to the Child Protection policy

the story given was consistent, and the parents had sought immediate help. The Paediatric Consultant was aware that Baby M was on a Child in Need Plan, however details of the plan were not known. Following this review, the Paediatric Consultant felt that this injury was accidental. The plan was to complete a CT scan, observe the pain relief and for the case to be discussed with the CIN Social Worker to get details of the Child In Need Plan.

12.37 During the remainder of the 27/11/2014 Baby M had a range of tests and consultations, including a consultation with the Plastics Team regarding his facial injury. The Specialist Registrar who saw Baby M noted that the bruise was likely to be less than 24 hours old. He also examined the small tear to the frenulum and concluded that no medical intervention was required.

12.38 A CT scan was undertaken which confirmed that the initial diagnosis regarding a skull fracture was correct and Baby M had a linear fracture to the left parietal. Following this diagnosis a decision was made to admit Baby M to the ward for 48 hrs for observation. There was consultation between the hospital and Children's Social Care during this time. The CIN Social Worker advised the ward that she would no longer be working for Children's Social Care and that the case would be reallocated. She also informed the Ward Nurse that the case was due to be '*downgraded*' but that the decision was likely to be reviewed in light of the injuries. The CIN Social Worker did not suggest a strategy meeting take place nor did the nurse request that consideration be given to this. During the conversation the CIN Social Worker advised the nurse that she would be speaking to the parents the following day.

12.39 Following her visit a second call was received from the CIN Social Worker to the hospital ward advising them that she was leaving her employment with immediate effect and she provided alternative contact details for the hospital. The Ward Nurse was informed by the CIN Social Worker that Baby M's Father was not supposed to be staying overnight and the nurse requested that this information should be confirmed the following day. There is no mention in the IMRs as to whether this happened or not.

12.40 Baby M was discharged from hospital on the 30/11/2014 into his parent's care. The explanation provided by the Father was accepted by hospital staff and Baby M went home with both parents. He stayed with his maternal grandmother on the night of the 03/12/2014 then returned to the care of his parents on the 04/12/2014. The CIN Social Worker spoke to the hospital but did not challenge the decision regarding the injuries being accidental. A strategy meeting did not take place whilst Baby M was on the ward or prior to discharge however there is record of a telephone strategy discussion[21] between Children's Social Care and Thames Valley Police on the 3/12/2014. The outcome of this strategy discussion was that the case did not hit the threshold for S47 investigation and the agreement was that Children's Social Care would continue with their involvement as a '*single agency case*[22]*'.* There is no explanation as to why this strategy discussion was so delayed or why there were only the two agencies involved.

12.41 Children's Social Care continued with the plan to work the case under Child In Need procedures despite the lack of joined up working in the previous three months and risk never really being considered. There was a view that the care given to the baby by both parents was of a good standard. A file audit took place and it is recorded in the Children's Social Care IMR that the auditor noted: "*this case has not been worked properly by the allocated Social Worker in the previous three months since Baby M's birth therefore it is not considered appropriate to step up to child protection"* .

12.42 Baby M was seen at home by the Social Work Team Manager on the 01/12/2014. He was at home with his Mother and MGM and there is little of note recorded about this visit other than it took place. This in itself is of concern given the events of the 27/11/2014.

[21] Working Together 2015 states there should be a strategy discussion involving Children's Social Care, Health, Police and other agencies whenever there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm.

[22] Thames Valley Police IMR 4.201

12.43 Baby M was readmitted to hospital by ambulance in the early hours of the 05/12/2014. He presented as floppy and unresponsive with intermittent twitching of all four limbs. A full physical examination on admission noted significant bruising and marks to the body and head.

Second Hospital Admission - Friday 5th December 2014

12.44 On the 04/12/2014 Baby M had been presenting as unwell. At about 11.30pm his parents reported that he had stopped breathing momentarily and was floppy and unresponsive. His parents did not call an ambulance until approx. 4.30 am on the 05/12/2014 some five hours after this incident. At 4.37am on the 05/12/2014 an ambulance was dispatched from South Central Ambulance Service to the home of Baby M after a 999 call was received. Ambulance staff on arrival noted that Baby M was shaky, jittery and cool to the touch. The ambulance staff took Baby M straight to A&E and he was taken into resuscitation.

12.45 The Paediatric Registrar[23] took the history from Baby M's Mother and she reported that Baby M was "grizzly" in the morning when he returned from his maternal grand-mothers home. However he fed through the day, but became fussy with his evening feed, he went to bed but awakened at 11pm and refused to take his night feed. Mother reported that Baby M's Father gave Baby M 2.5ml of paracetamol, and then Baby M became floppy and stopped breathing momentarily. Mother stated Father didn't have time to do anything because Baby M was back to normal quickly. However shortly after midnight his parents reported that Baby M was pale and had begun shaking. Baby M's parents put him skin to skin in bed, but eventually called an ambulance.

12.46 The Paediatric Registrar noted the delay in mother bringing Baby M to A&E. Mother stated she was reluctant to call an ambulance because she said they hadn't attended previously when Baby M fractured his skull. A full physical examination was undertaken of Baby M and a detailed history and body map was completed. The

[23] IMR BHT Acute Sector

Mother could offer no explanation for the injuries seen and rather than appearing concerned about Baby M she spent her time texting on the phone. It was noted she did not attend to his needs; she did not talk to or try to reassure him. The Paediatric Registrar felt that there was a significant indication of non-accidental injury and therefore planned for a CT scan, skeletal survey, bloods, ophthalmology assessment, medical photography, and, to rule out any possible medical conditions, a lumbar puncture was also undertaken. During this process Baby M's Mother was kept fully informed of what was happening.

12.47 Discussions took place between Children's Social Care and the hospital during the morning of the 05/12/2014 and the decision was made that Baby M should not be discharged from hospital without a strategy meeting taking place. Examinations and tests continued in the hospital during the day including medical photography seeing Baby M and taking photographs of multiple sites of injury. The Children's Social Care Practice Improvement Manager (PIM) contacted Thames Valley Police requesting a strategy discussion and Referral Manager 38 at Thames Valley Police rang her back at noon. The PIM shared the information regarding the injuries noted on Baby M's back, leg and forehead and the delay there had been in getting him treatment. Referral Manager 38 confirmed that the Police would attend a strategy meeting on the 08/12/2014. It is not clear from the Police IMR or the Children's Social Care IMR as to whether this '*discussion'* was viewed as a strategy discussion, however what did not happen was an agreed plan to safeguard Baby M over the coming weekend nor was a decision taken to instigate a S47 investigation.

12.48 There was consultation also on the Friday 05/12/2014 between the Children's Social Care PIM and Buckinghamshire Law Plus regarding the arrangements for Baby M. It has become clear during the review that full information sharing did occur and that the information received by Buckinghamshire Law Plus was limited .The Buckinghamshire Healthcare NHS Trust (BHT) Acute Services' IMR and subsequent clarification received from them states that the information shared with Children's Social Care regarding Baby M's presentation indicated that infection was only one of two possible reasons for Baby

M's presentation at hospital with the other reason being NAI, however there was still concern about the delay taking Baby M to hospital of some five plus hours despite the mother stating that Baby M had momentarily stopped breathing. This alone is a cause for grave concern. What is clear in the responses and recording of all three of these agencies is that on the Friday the hospital were in the process of completing full child protection medical procedures including a skeletal survey, eye examination and that the decision had been made to call a strategy meeting for the Monday 8/12/14.

12.49 A further issue for the hospital on this Friday was how to manage the parents on the ward as they had informed Children's Social Care that they couldn't have staff with Baby M all of the time he was an inpatient. The Consultant explained that the hospital could not keep an eye on Baby M at all times when the parents were around. Following this call the Children's Social Care PIM discussed this case with the legal team. It is recorded in the medical notes that the advice was that there were not enough grounds to ask for supervised visits, therefore ward staff were just to observe the interaction of parents with Baby M. Due to the previous CIN Social Worker for Baby M leaving the case had been reallocated to a new CIN Social Worker and she visited the ward late afternoon and met with the parents. An agreement was made with the parents for Baby M to stay on the ward over the weekend but no restrictions were in place regarding Mother or Father visiting.

Saturday and Sunday 6th & 7th December 2014

12.50 Baby M remained on the ward over the weekend; his scans were reviewed by the Neurosurgical Registrar at a tertiary hospital and concerns were noted about the low density observed around the temporal lobe. The registrar was unsure whether it showed encephalitis and as a result a lumber puncture was carried out. Test results identified that Baby M did not have sepsis or any other medical reason for his injuries. Further reviews of Baby M's condition continued over the weekend and no new concerns were noted.

Monday 8th December 2014

12.51 Baby M was reviewed medically on the Monday and continued to present with no new concerns. An assessment was undertaken by the Ophthalmologist later that day. During this examination they noted that Baby M had bruising/ petechial and haemorrhages present in his right eye. Later that day a strategy meeting took place at the hospital and was attended by the Consultant Paediatrician, Named Nurse, Acting Detective Sergeant 39 from the Child Abuse Investigation Unit, Baby M's CIN Social Worker, the Practice Improvement Manager and a Solicitor from Buckinghamshire Law Plus. During the meeting concern was raised regarding the parents' lack of attachment to Baby M, an issue that had not previously been raised by professionals working with the family. The outcome of the strategy meeting was that the injuries to Baby M were non accidental and a section 47[24] investigation was to be instigated. The CIN Social Worker intended to speak to the parents to seek agreement to Section 20 accommodation.[25]However, there is some confusion between the Police and Children's Social Care recording regarding this matter. The Police recorded following the strategy meeting, that the parents had signed a Section 20 agreement; however in the Children's Social Care records this was not the case and no agreement to S20 was achieved. The plan following the strategy meeting was for Baby M to remain in hospital and from this point onwards contact was to be supervised by a CIN Social Worker. The solicitor from Buckinghamshire Law Plus was in attendance at the strategy meeting and it was an outcome of the meeting that legal proceedings would be initiated and Baby M would be discharged into foster care. A flag was added to the hospital's address on Thames Valley Police's Command & Control database which advised any officers attending following a call from the ward of the situation re Baby M and advising them to consider using their Police Protection Powers[26] if required.

[24] Section 47 of the Children Act 1989 is a Children's Social Care led assessment of a child which also involves other agencies when there is reasonable cause to suspect that a child is suffering or likely to suffer significant harm in the form of physical, sexual, emotional abuse or neglect
[25] Section 20 of the Children Act 1989 relates to the Local Authority's duty to provide accommodation for any child in their area who needs somewhere to live.
[26] Section 46 Children Act 1989 allows the police to safeguard a child in an emergency if they are at immediate risk of significant harm.

12.52 The CIN Social Worker for Baby M spoke to Baby M's maternal grandmother following the strategy meeting and the grandmother questioned whether Baby M's Mother had understood the information she had been given, making reference to her having a 'learning disability'. She also advised the CIN Social Worker that she was concerned that the parents were hiding something.

Tuesday 9th December 2014

12.53 On 9th December Baby M's Mother and Father were interviewed under caution at Aylesbury Police Station. They voluntarily gave Police their mobile phones for examination and allowed access to their address for photographs to be taken. That morning the Police photographer had also attended at the hospital to take photographs of Baby M's injuries. Baby M's CIN Social Worker also arrived at the Police station to see the parents and she served them papers for a court hearing the following day. The Social Worker returned Baby M's Mother home. Baby M's Father was to be returned home later that day by the Police who had identified him as vulnerable. When the Social Worker saw both parents at the Police station they had been asked to agree to Baby M being accommodated under Section 20 of the Children Act. Despite taking Baby M's Mother home the CIN Social Worker did not go through the paperwork and ask Mother to sign the forms but left them with her. Later attempts to contact the parents to sign the Section 20 agreement were unsuccessful and on the 10/12/2014 an application was made to the courts for an Emergency Protection Order.

12.54 A skeletal survey was carried out on the 10/12/2014 and Baby M was found to have numerous rib fractures identified at different stages of healing. From the admittance of Baby M on the 05/12/14 five days passed before Baby M had a full skeletal survey. It has not been possible to ascertain what the delay regarding this was. It is possible that Baby M being admitted just prior to the weekend may have had an impact however the IMR author for BHT Acute Services identified that there is always an on call Radiologist available and the service should have been available.

13 CRITICAL ANALYSIS OF CONCERNS

Assessments

13.1 A range of assessments were undertaken by agencies including Children's Social Care, Youth Offending Service, BHT Acute and the Children & Adolescent Mental Health Services (CAMHS) however there was no holistic assessment undertaken which looked at the needs of unborn Baby M and collated together all of the information from the many agencies involved with the family. As the lead agency for safeguarding, Children's Social Care should have undertaken this role. The Child and Family Assessment in respect of Baby M highlights significant areas of risk and concern which required further action however it was not identified how those risks were to be managed or further assessed. There was delay in the assessment starting; the referral from the Community Midwife was made on 20/03/2014 however the Social Worker in the First Response Team did not commence work actively on the assessment until 27/04/2014. It is of concern that the First Response Social Worker was able to make a judgement in a very short space of time that the case was to be managed under a Child In Need Plan despite the assessment being incomplete.

13.2 The IMR author notes that had this assessment been completed in a more timely way it would have provided the basis for further action. What is of concern in this assessment is that the First Response Social Worker has focussed on the housing need for Mother and also attempted to access a range of services for her vulnerabilities but this has taken the focus off the risks that were evident and present and noted in the assessment for Baby M. The analysis of the Child and Family Assessment concluded that further work was to be undertaken and the case was to transfer to the Child In Need Unit. A referral was made for a pre-birth assessment but no other support was in place and the assessment recommended continued liaison between Baby M's Father's Children in Care Social Worker and the CIN Social Worker for unborn Baby M.

13.3 The pre-birth assessment undertaken by the Junior Catch Team was totally inadequate and did not grasp the issues relating to the family at all. Rather than a risk assessment being undertaken the assessment focussed on the parents' ability to undertake basic care tasks. The Child and Family Assessment had highlighted considerable risk yet upon transfer the Social Worker in the Child In Need Unit did not guide the pre-birth assessment being undertaken by Junior Catch but rather it appears has disengaged from the process. The delay in the pre-birth assessment starting resulted in Baby M being born before the assessment was half way through. The IMR author[27] noted that the assessment had '*limited value*' and was not an adequate assessment upon which to base an assessment of risk and capability of the parents and the provision of services.

13.4 The parents of Baby M were well known to a range of agencies including Children's Social Care, Thames Valley Police, Youth Offending Service, CAMHS and Connexions. The information held by the various agencies highlighted concern about the high vulnerabilities of both of the parents and the risks associated with Baby M's Father in respect of violence and drug misuse. Upon receipt of the referral for Baby M Children's Social Care did not routinely make checks with other agencies, despite these agencies holding a wealth of information which would have informed decision making and assessments outcomes. The decisions in this case were made prematurely and without sufficient investigation. Children's Social Care did not take on a coordinating role to ensure that all agencies working with the family contributed to the assessment. There was no co-ordinated multi-agency response to those identified risk factors which would have formulated a meaningful plan of intervention.

13.5 There was a failure by all agencies to take a holistic view of the family, with incidents and concerns being treated in isolation. The exchange of information and communication between all agencies was inconsistent and agencies did not always follow up on concerns once they had referred the matter through to Children's Social

[27] Children's Social Care IMR

Care. There were a number of occasions when the use of escalation would have been appropriate. An example of this is with the first injury there was no challenge from CSC regarding the mechanism around how the bruises and torn frenulum had occurred. Also in respect of this first presentation at hospital the Paediatric registrar had documented the injuries to Baby M in detail and had recommended amongst other tests a skeletal survey and was clearly considering a non-accidental injury. This decision was over ruled by the consultant who was on duty during the day and believed that the parent's explanation fitted the injuries observed.

13.6 Despite evidence to the contrary professionals displayed optimism about the parent's ability to provide appropriate care for Baby M. The range of risk factors known regarding both parents were not investigated or interrogated in a meaningful way. The First Response Social Worker makes reference to having concerns about Mother's capability; there were concerns about her learning and vulnerabilities. This vulnerable young mother had limited family support and a partner who in his own right was extremely vulnerable and displayed a range of behaviours and volatility which should have alerted professionals to the potential risk to the baby. Yet despite these concerns it is evidenced several times in this case that there was an overly optimistic view rather than a robust analysis about how these parental vulnerabilities impacted on their parenting capacity. (e.g. '*However my gut instinct is that the risk is minimal*'[28]….. "*He does not present with concerns as a potential Father. By nature of his status he will be vulnerable*"[29]). It is possible that in some of these instances the "rule of optimism"[30] resulted in an unrealistically positive interpretation being put on the behaviour of the parents.

13.7 Baby M's Father had a number of assessments completed during the review period. Due to the concerns regarding his previous offence in respect of a firearm the Risk of Serious Harm ASSET was undertaken when he was on a Referral Order. The information regarding his risks are clearly documented in this assessment and

[28] Youth Offending Service IMR
[29] Social Care IMR 4.2.28
[30] Blom-Cooper L, et al. A child in trust. The report of the panel of inquiry into the circumstances surrounding the death of Jasmine Beckford. London Borough of Brent: Kingswood Press, 1985.

the Children In Care Social Worker attended the Risk and Vulnerability panel where the concerns regarding Baby M's Father were discussed and he was identified as being a medium risk of harm to others. However this assessment does not appear to have been considered by Baby M's CIN Social Worker or managers to have influenced any decisions around risk.

13.8 When Baby M presented at hospital on the 27th November 2014 at the point of presentation he had suffered significant harm either intentionally or unintentionally whilst in the care of his parents. Information gathered during the triage process identified two separate incidents which resulted in injuries to Baby M. The first injury which was a bruise to the area below the right eye area happened the day before his presentation on the 27/11/2014 and this issue was not picked up following the initial consultation with the Triage Nurse. The Registrar does not appear sighted on the fact that there were two separate injuries. Neither the Triage Nurse nor the Registrar questioned why a non-mobile baby would have two separate injuries within such a small timescale. The A&E Doctor was unable to reach the radiologist despite ringing and bleeping and as a result a skeletal survey did not take place. There was no healthy scepticism or challenge to the story that parents were telling and staff at the hospital accepted what they were being told by Baby M's Father. There was no forensic analysis of the injuries Baby M presented with to establish if they could have happened in the way Baby M's Father stated. The Specialist Registrar from the plastics team did not query the mechanism for the injuries despite the bruise observed and the torn frenulum. This was compounded by the CIN Social Worker who also accepted wholeheartedly that this was an accidental injury despite having a considerable understanding of some of the risks factors surrounding Baby M's Father.

13.9 Despite Baby M suffering significant harm there was no multi-agency strategy meeting[31] on the 27th or 28th November 2014 to share information, to make

[31] Strategy meeting is held to determine whether there are grounds for a Section 47 investigation and should involve the key individuals from the relevant agencies.

decisions about what the next steps should be, or to decide if a S47 investigation should have been initiated. Working Together 2015 makes it clear that a Section 47 enquiry should be initiated to decide if and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm. Without a strategy meeting full information sharing did not take place.

13.10 The second presentation at the hospital and the subsequent management and failure to safeguard him is extremely concerning and action needs to be taken by BSCB to ensure that procedures are immediately adhered to. There was a systemic failure by Thames Valley Police, Children's Social Care, Buckinghamshire Law Plus and BHT Acute Services to safeguard Baby M from when he was admitted in the early hours of Friday 05/12/2014 with an initial presentation, which was highly suggestive of a non-accidental injury, to the date of the Emergency Protection Order some five days later. A full physical examination on admission noted significant bruising to the head and body for which Baby M's Mother could offer no explanation. The injuries noted on the body maps and in the detailed notes taken include bruises of red/purple colour to the cheek, left wrist, right lower leg/ankle, mandible and back. There was also swelling to the entire right cheek and petechiae over the forehead, bridge of the nose, upper back and eyelids. Child Protection procedures designed to protect him were not followed. On the 5/12/2014 there should have been an immediate strategy meeting with at least the Police, A&E Doctor, Legal representative and Children's Social Care in attendance and from this meeting a plan should have been put in place to safeguard Baby M. The weekend was approaching and this vulnerable baby was on a ward with both his parents in attendance. What was known on this Friday was that Baby M had been admitted a few days previously and presented with two separate incidents which had resulted in multiple injuries which he could not have inflicted himself.

13.11 The quality of information sharing and subsequent advice given, due to inaccurate and incomplete information sharing between Children's Social Care, BHT Acute Services, Thames Valley Police and Buckinghamshire Law Plus on the

5/12/2014was extremely poor. Buckinghamshire Law Plus could have challenged more robustly Children's Social Care, BHT Acute Services and Thames Valley Police regarding the decision not to hold an immediate strategy meeting to ensure that they were fully informed about Baby M's injuries and able to influence a plan to safeguard him. Buckinghamshire Law Plus have a wider professional duty and could have more strongly challenged poor working together by these other agencies. In the Fact Finding hearing for the Care Proceedings the Consultant reported a high index of suspicion of inflicted injury. A full physical examination on admission noted significant bruising and marks to the body and head for which there was no plausible explanation. On the 5/12/14 Baby M was considered by all agencies to have either suffered a non- accidental injury (NAI) which resulted in his multiple bruising or there was an underlying medical condition which at that stage could not be ruled out due to his extremely poor medical condition. There were a number of multiple factors which should have alerted Children's Social Care, Thames Valley Police and Buckinghamshire Law Plus to view the injuries with scepticism and to have taken a more robust stance:

- There had been a delay in Baby M's presentation at hospital in excess of five hours – this was despite him appearing to have stopped breathing. This was reported by the parents to ambulance staff.
- He had been floppy and unresponsive when paramedics attended him at home and needed immediate medical support. He was noted to be covered in multiple bruising and was extremely poorly on admittance at hospital.
- Parents could offer no plausible explanation for Baby M's bruises.
- Baby M had only days earlier presented at hospital with bruising to his face, eye, had a fractured skull and a torn frenulum.
- Mother did not appear overly concerned whilst Baby M was being attended to in A&E and spent her time texting on her mobile phone.

13.12 The above factors should have ensured that Thames Valley Police, Children's Social Care and BHT Acute Services were alerted to the high possibility of NAI and Baby M and this information should have been communicated to Buckinghamshie Law Plus to ensure that there was a robust safeguarding plan in place. The parent should have been invited to leave and not stay at the hospital. Had they refused against this background then they would have given the grounds for the Emergency Protection Order (EPO). Nationally there is often a reluctance to take matters before the court for an Emergency Protection Order[32] because of the very draconian nature of this order and the threshold for removal of a child from his parent's care being rightly very high. Courts have to balance the rights of a child to be safeguarded and protected and the human rights of both child and parent to a family life. The local authority has to evidence compelling reasons why such an order would be necessary and proportionate.

13.13 It is the opinion of the Independent Reviewer that the advice given by Buckinghamshire Law Plus was made without the full knowledge of all of the information available and thus the actions taken by Children's Social Care not to agree a safeguarding plan or to issue immediate legal proceedings was flawed and failed to ensure Baby M was safeguarded. He was left in hospital on a busy ward with his parents caring for him when it was highly probable that one or both of them had been responsible for his injuries. The hospital was carrying out its normal procedure where a child has unexplained injuries and ensuring that there was not an underlying medical reason for the injuries as well as maintaining that outside of this explanation the injuries were highly suspicious of a non-accidental mechanism. The strategy meeting on the 08/12/2014 agreed that the threshold for legal proceedings had been met and a safeguarding plan was put in place until the 10/12/2014 when a legal order was secured. The Fact Finding hearing in the Care proceedings indicted that the date of some of Baby M's fractures to the anterior right 8th, 10th and 1st rib

[32] http://www.proceduresonline.com/buckinghamshire/chservices/chapters/p_app_emer_prot_ord.html
An Emergency Protection Order (EPO) enables a child to be removed from where s/he is, or to be kept where s/he is, if this is necessary to provide immediate short-term protection. The EPO will grant the local authority Parental Responsibility for the child which will enable the child to be removed to other accommodation or to remain in a place where he/she is being accommodated (e.g. a hospital or foster placement).

occurred between the 29/11/2014 and the 10/12/2014. Five of these days fall within the timeframe for when Baby M was left on a busy ward in the care of his parents. While it is not suggested that these injuries occurred on the ward the lack of action on the 05/12/2014 regarding a robust safeguarding plan raised the risk that he could have potentially suffered further injuries.

13.14 Management oversight in general was limited in the Children's Social Care records and it appears that the case was not on the radar of first line managers as being significant. Therefore it would not have been flagged up to senior managers for advice or guidance.

13.15 Child In Need processes were not followed, there were no active planning and review processes built into this. There was no multi-agency mechanism which enabled agencies to share information and concerns in a co-ordinated way to ensure assessment and subsequent plans of intervention were based on the evidenced risks. Child in Need processes were not embedded on a multi-agency level across the partnership and there is little mention of how these cases should be managed. The Buckinghamshire Safeguarding Children Board's Individual Case Management Procedures, which are available on the BSCB website, had not been updated since 2010 and there were no links to the more detailed Social Care procedures relating to Children in Need. In February 2015 Children's Social Care moved to an online procedures manual which is now linked to the BSCB website. However, the Safeguarding Board's Individual Case Management Procedure has not yet been updated in line with this resulting in a lack of clear and easily accessible to guidance for professionals on case management.

13.16 There was also a distinct lack of professional curiosity displayed in this case and this was particularly apparent in relation to the first admittance to hospital with the two separate injuries which occurred to Baby M. There was an acceptance by professionals and little challenge to the information provided by the parents. The transfer of the case from the Triage Nurse to the Registrar resulted in there not being sufficient rigour given to the mechanism surrounding a non-mobile baby

receiving two separate injuries accidently. There is no evidence of challenge by professionals who received this information.

13.17 There are several instances of poor recording and information not being clear in records and there was no Child In Need Plan in place which agencies involved appeared to be working towards or monitoring. Where there are safeguarding issues identified the multi-agency mechanisms of a Child Protection Conference was not given consideration by agencies; therefore the formal processes for multi-agency review and planning are not implemented. There is the same expectation that similar process around planning and reviewing in relation to Child In Need cases should take place but it does not appear to be embedded as practice amongst agencies.

14 RESPONSES FROM THE KEY LINES OF ENQUIRY

14.1 The Children's Social Care records indicated that there was limited management oversight in relation to this case. The Child and Family Assessment took from March to June 2014 to be completed which is outside of timescale and, although risk factors were identified, it does not appear that the Team Manager or the Social Worker formulated a plan of how to manage this risk or move the case forward. The IMR author identifies that the vulnerabilities of Baby M's Mother in respect of her learning difficulties were highlighted in the assessment and the First Response Social Worker was concerned that the housing options for her were inappropriate and would take her away from her current sources of support and could place her *"at the mercy of some exploitative individuals".* The IMR author identified that workers for both young people had commented to her that whilst presenting with difficulties both Baby M's Father and Mother could also be insightful and appeared to support each other and work well together.

14.2 The Children's Social Care records identify some evidence of disguised compliance with Baby M's Father and Mother giving different information to different professionals and because agencies were not working actively together this

information was not triangulated in a meaningful way. An example of this was identified by the Children's Social Care IMR:

'*For example in September 2014 Baby M's Father was asking his PA about sharing the tenancy with Baby M's Mother but the ICS records says he is bidding for his own tenancy. Children in Care Social Worker said he told her he had saved £400 for the baby but at the time he was stealing food.*'[33]

Baby M's parents gave agencies fragmented information which if triangulated may have indicated concerns. The Biennial Review of SCR's 2005-2007 [34]identified that 75% of parents do not engage with services despite appearing to do so.

Baby M's parents also managed to persuade medical staff on the 27/11/2014 that the injuries to Baby M had a totally accidental mechanism and the BHT Acute IMR Author commented that (NICE) 2009 guidance on when to suspect child maltreatment indicates that maltreatment may have occurred if bruising is found in a child who is not independently mobile[35]. Baby M had a significant head injury, torn frenulum and bruising under his eye yet although non accidental injury was considered by the Registrar this was then dismissed by the Paediatric Consultant. Some medical staff did not consider that "*they should think the unthinkable"*[36]*.* Lord Laming (2003) commented following the death of Victoria Climbie about the need for *"healthy scepticism" and respectful uncertainty in their dealings with families"*[37] and the need to verify information from other sources while listening to what parents have to say. "*One of the most problematic tendencies in human cognition….is our failure to review judgement and plans-once we have formed a view on what is going on , we often fail to notice or dismiss evidence that challenges that picture"*[38]

14.3 Positive outcomes were assumed despite clear indicators that the opposite was to be a more likely outcome. The IMR author for Children's Social Care has

[33] Children Social Care IMR
[34] The Biennial Review of SCR's 2005-2007
[35] The National Institute for Health and care Excellence
[36] http://www.coventry.gov.uk/downloads/file/17081/daniel_pelka_-_serious_case_review_overview_report
[37] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273183/5730.pdf
[38] Fish S, Munro E and Bairstow S(2008) Learning together to safeguard children pg 9

identified that at the very least the outcome of the assessments and information known about both parents should have led to a Child Protection Case Conference. It is the view of the Independent Reviewer that had all of the information been shared when the referral first came into Children's Social Care in March 2014 and a robust assessment undertaken based on multi-agency information then this matter should have progressed into the Public Law Outline process[39]. If this had occurred and assessments had been completed before Baby M was born then it is likely that different decisions would have been made for him. Assessment does not seem to have been an ongoing process that evolved with the case but a one off event, and the past histories that both these young people had experienced did not inform the assessments undertaken.

14.4 The assessments undertaken in A&E during the first admission were in line with local protocol, however information in the social history taken was sketchy and a recommended ophthalmology assessment did not take place. It was accepted by the Consultants who reviewed Baby M that the injuries had an accidental mechanism. It was not considered that he could have been shaken or whether there would be other injuries that were not so obvious. The Paediatric Consultant stated to the IMR author that it was his role to question "was the injury possible?" The IMR comments that using the same logic it can equally be assumed "that it is not possible".

14.5 A skeletal survey was not undertaken during the first admission on the 27/11/2014. During the second admission the skeletal survey was delayed until the 10/12/2014 and revealed the following injuries for Baby M:

- Healing fractures to the right 3rd,6th,7th,8th and 9th ribs at the costovertebral junctions with new bone evident
- Further incomplete fractures on the anterior 8th, 9th and 10th ribs on the right showing no healing by new bone formation.

[39] https://www.justice.gov.uk/courts/procedure-rules/family/practice_directions/pd_part_12a

- Healing fractures to the left 4th, 5th, 6th, 7th, 8th, 9th, and 10th in the postero lateral position with early new bone formation evident.
- Fracture of the 1st rib on the left showing distraction (separation) at the ends of the fracture with no healing bone formation

The judgement in the Finding of Fact hearing found, based on expert testimony that the skull fracture and the first rib fractures occurred during a single incident on the 27/11/2014.

The lack of a skeletal survey during this first admission meant that the scale of injuries Baby M had suffered were not fully realised and conclusions were reached that the injuries had been accidental. Had this skeletal survey taken place then he would have been unlikely to have returned home with his parents where he received further injuries.

14.6 The Thames Valley Police IMR author identified a number of occasions when information sharing from the Police was not effective. In general, information exchange and communication between the agencies was inconsistent and at times poor.

14.7 From the date of the notification of the pregnancy the family came into contact with a range of agencies and received many services. Few services and interventions had a positive impact on either parent or Baby M. Family Nurse Partnership (FNP) is a service that may have had a positive impact and would have provided high levels of support to these very young parents in both the pre and post birth periods. FNP can help safeguard some of the most vulnerable and costly families as they take a whole family approach as well as working with mothers. A report by The Centre for Social Justice identified that at least one in ten care leavers are parents who have had a child taken into care in the last twelve months[40]. FNP does not operate a waiting list and they are required to take a prescriptive approach

[40] Finding their Feet, Centre for Social Justice

to their interventions. A recommendation of the report was that the NHS should make Family Nurse Partnership a default position for all Looked After Children and care leavers and the Independent Reviewer of this review would echo that recommendation. In October 2015 the responsibility to commission and extend the coverage of Family Nurse Partnership will rest with the Local Authority due to the transfer of public health arrangements to Local Authorities and consideration should be given to how this service can be targeted at those young parents most in need.

15 ORGANISATIONAL CONTEXT ISSUES

15.1 The period covered by this Serious Case Review includes the period leading up to the inspection of Children's Services by Ofsted in June 2014 and the period following the inspection when the Improvement Plan was in place and many of the findings of this review were known during and after the inspection. The Ofsted report indicates that it was recognised by senior managers and political leaders that there were serious problems within the system and that despite injections of funding changes had not been effective. Further, Ofsted commented that the "*failures by Buckinghamshire's safeguarding services are widespread and serious. The result is that children are not being effectively protected. Children and young people do not always receive help when they need it*"[41]. Within this case there is clear evidence of what was being experienced within the organisation. Social work caseloads were high and records often poor. A reorganisation of the service into Units had impacted and the social work units introduced functioned with a smaller number of staff using a method of work called "systemic practice". The problem was exacerbated by difficulties in recruitment and retention as there had been significant movement of staff when the new structure was introduced.

41 reports.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/buckinghamshire/051_Single%20inspection%20of%20LA%20children%27s%20services%20and%20review%20of%20the%20LSCB%20as%20pdf.pdf

15.2 The IMR for Thames Valley Police did not identify any significant contextual information which had an adverse impact upon their practice.

15.3 The IMR completed for the Health Visiting Service identified that there were a number of factors which could have impacted upon practice during the period of the review. The Team Leader was new to the team and the IMR author identified that challenging the existing CIN Social Worker, who had a strong personality, was a possible issue. The Team Leader also described pressure within the organisation for staff to perform and achieve Key Performance Indicators (KPI) targets. This created conflict and also a lack of understanding around how to prioritise workload.

15.4 The IMR for BHT Acute services identified that there were no specific issues of capacity identified within A&E and Ward 3, which were felt to impact the quality of services provided for Baby M. The IMR author interviewed both Consultants who were involved in Baby M's admission on 27/11/14 and they both agreed that there were no unusual issues, apart from Baby M being an inpatient during the weekend, which is generally a busier time. The Ward Nurse stated that the Paediatric Day Unit (PDU) is always extremely busy in October and November as it is the start of the season where there is an increase in admissions due to respiratory issues and, although staff in PDU always feel more staff are needed, she felt on this date there were ample staff available and a good skill mix on duty.

15.5 The GP IMR has identified that there were no capacity issues in the surgery which would have impacted on the care given to Baby M's Mother or Baby M. What is noted is that Baby M's Mother booked 'on the day' appointments with GPs and this resulted in a lack of continuity of care as she would have not been seen by the same GP. Had she booked routine appointments she would likely be under the care of the same GP. Positively each booked ante-natal appointment was with the same Community Midwife

15.6 The Youth Offending Service IMR has not identified any organisational difficulties that were experienced within or between agencies in relation to this review period. Staffing levels were adequate and there was no impact of annual or sick leave during that time.

15.7 The BHT Maternity IMR has not identified any adverse organisational issues which impacted on service delivery. The IMR author however has commented that there were capacity issues in respect of the Teenage Pregnancy Liaison Midwife who had reduced her working hours and the team were in the process of recruiting a job-share partner for her.

15.8 Family Nurse Partnership received the notification about mother's pregnancy in February 2014. The service was in its first year at this time and caseloads were at capacity. They had met their commissioned contract but were in the process of building a business case for increased capacity. This was agreed and they are now able to offer the service to approximately 50% of the eligible population at any one time. The service is now established and has grown, clients are graduating the programme every month (they stay in the programme 2 ½ years). This means that they now have a constant flow of clients in and out of the programme, which was not the case in early 2014. They have also made a commitment to prioritising those clients according to geography and need and agreed that all LAC clients will be offered FNP in Buckinghamshire.

16 GOOD PRACTICE

16.1 An area of good practice was observed during Baby M's second admission, when the assessments completed were thorough and considered all risks for Baby M. The Paediatric Registrar acted promptly and informed Children's Social Care of her concerns immediately.

16.2 The completion of the Risk of Serious Harm ASSET would not be normal practice for the Youth Offending Service to complete for a young person with an offence of

Possession of Cannabis. However, due to Baby M's Father's previous offending history, this was completed and identified the' *risk of harm to others* 'status for him as being medium.

16.3 There were no other examples of good practice above and beyond what was the normal expectation of agencies and individual workers.

17 LEARNING EVENT

17.1 A Learning event took place with practitioners using appreciative inquiry[42] was held and was attended by agency representatives, a total of twenty practitioners and police attended. The learning event had previously been scheduled to take place at an earlier date but concerns from Thames Valley regarding the ongoing police enquiries had resulted in this being postponed and ultimately a delay in the completion of this Serious Case Review. This was despite reassurances that ACPO[43] guidelines would be followed and that officers could be in attendance on the day. Prior to the event a brief summary was shared with practitioners and themes explored through appreciative inquiry and group discussion and workshops. Practitioners who attended the event were honest and candid in their responses and many of the hypothesis were able to be tested out and triangulated.

18 FINDINGS AND RECOMMENDATIONS

18.1 A question that this review has to answer is whether or not Baby M could have been protected earlier. This review does conclude that Baby M could have been

[42] Appreciative Inquiry is a theory and applied practice as a model for analysis that is co-operative and asks questions to strengthen the understanding of systems and organisations.

[43] http://www.baspcan.org.uk/files/120614%20SCR%20and%20Criminal%20Proceedings%20Guidance%20Document%20June%202014%20Final.pdf

protected at an earlier stage. In the pre-birth period there were enough indicators of risk to predict potential harm and the systemic failures following the first admission to hospital ensured that Baby M was returned home with his parents to be further abused.

18.2 There is recognition that the poor planning in the pre-birth period was a missed opportunity in this case and in another Serious Case Review that has taken place in Buckinghamshire. The 2015 Baby K SCR[44] makes reference to an "*inadequate pre-birth assessment…which did not lead to a robust plan".* The Healthy Child Programme[45] highlights the importance of recognising risk factors in both pre and post birth periods. In this case the pre-natal risks were not considered or analysed. Whilst there are meetings in place between BHT Midwifery and Children's Social Care to try to identify vulnerable babies these lack structure and do not adequately track unborn children through the system. The SCR for Baby D, another Buckinghamshire baby, carried out in 2012, identified that the risks in that pregnancy were deemed as low therefore the case was not referred to Children's Social Care. As in this case the baby's mother presented at hospital on a number of occasions with vague symptoms which may have been indicative of Domestic Abuse. When she did inform the GP that she was experiencing Domestic Abuse assumptions were made about the Police dealing with the matter resulting in the GP not following this up.

RECOMMENDATION 1: BSCB to ensure that there is a robust identification and tracking of unborn children. This will require current arrangements to be strengthened and will require multi-agency information sharing and working to ensure that risk is identified early and planning is robust.

RECOMMENDATION 2: The BSCB should ensure that all identified tracked vulnerable unborn children have an agreed birth plan in place prior to delivery to ensure that agencies are aware of the plan at birth and alerted when they have been born.

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Family Nurse Partnership

18.3 This Serious Case Review, and another review this author is undertaking, has highlighted the lack of service provision available nationally for young parents who have high needs. It is inconceivable that nationally provision such as the Family Nurse Partnership is not targeted at those young people who most need intensive support in the short, medium and long-term. In particular care-leavers who are to become parents should automatically fall within a target group for this provision, given they are likely to have experienced compromised parenting themselves. The responsibility for commissioning Public Health Services for Children aged 0-5 will transfer to Local Authorities from NHS England which brings opportunities to look at how the service is commissioned nationally. It is positive that locally in Buckinghamshire FNP will now be offered to all LAC and care leavers who are to become parents. However there is still a requirement for the mother to be referred to the service by 19 weeks and work will need to be undertaken across the partnership to ensure all practitioners who work with young and vulnerable parents are sighted on this.

RECOMMENDATION 3: NATIONAL RECOMMENDATION

That consideration is given to commissioning arrangements for the Family Nurse Partnership programme to be targeted at all young parents who are or have been Looked After Children / Care Leavers. This will ensure they receive the support required in the short, medium and long-term to enable them to develop the skills to successfully parent. Commissioning arrangements would need to consider local demographics and need.

Threshold Decisions

18.4 This case has identified that threshold decisions in the whole are not understood across the partnership. The case clearly had dimensions of risk and early indicators of harm or potential harm yet did not progress into the child protection arena. Confusion is evident between the Police and Children's Social Care as to whether a strategy meeting had taken place or not. Following the first admission to hospital the 'd*iscussion'* between the Police and Children's Social Care did not take place until three days post-discharge. The second admission to hospital left Baby M at risk and on the ward unprotected until five days after admission as the strategy meeting and S47 investigation decision were delayed. The response from Buckinghamshire Law Plus was wholly inadequate. The case of Baby M lacks effective management, oversight and challenge. The Ofsted inspection of June 2014 identified a range of failures, in particular responding to young people in need of help and protection. The findings of this report are in line with these findings.

RECOMMENDATION 4: For BSCB to urgently satisfy itself that current arrangements and understanding regarding threshold decisions are safe and robustly adhered to.

RECOMMENDATION 5: BSCB to assure itself that Strategy Meetings and S47 investigations are being carried out in line with policy.

RECOMMENDATION 6: BSCB to arrange a workshop comprising of representatives from key partner agencies to look at the systemic issues in respect of professional challenge which are particularly evident in this case, with a view to understanding how to ensure, in future cases, that professionals in individual agencies are able to challenge and escalate appropriately and that the current barriers which are impeding challenge are removed and partnership working strengthened.

RECOMMENDATION 7: BSCB should require agencies to review and provide evidence that staff are aware and have received training regarding the use of the escalation process and that there are systems in place which will support this. Regular audits to be undertaken to monitor the arrangements.

RECOMMENDATION 8: BSCB should ensure that up to date core procedures are easily accessible via the BSCB website.

19 Individual Agency Recommendations

As part of the methodology of this review it was agreed that each agency which provided an Individual Management Review would also provide a set of recommendations for improving services and practice within their agency. Each of the individual agency recommendations below are therefore directly drawn from the Individual Management Reviews and have already been agreed by senior managers within those agencies.

19.1 Children's Social Care

19.1.1 Develop a system for measuring, reporting and evaluating operational risk factors in units - *This action has already been progressed as part of the SCR for Baby K*

19.1.2 Carry out an Audit of the quality of recording for unit meetings in CIN units, including an evaluation of the quality of management decisions made during the meeting - *This action is already being progressed as part of the Ofsted improvement plan*

19.1.3 Monitoring systems for CIN cases - *This action is being taken forward as part of the Ofsted improvement plan*

19.1.4 Monitoring systems for supervision - *This action is being taken forward as part of the Ofsted improvement plan*

19.1.5 Where more than one unit is involved with children and young people, in one family, ensure the needs and risks of all the children and young people are jointly assessed and evaluated

19.1.6 Where a child is subject of a Child In Need (CIN) or Child Protection (CP) plan agreement to the discharge from hospital without a strategy meeting to be sought by the social worker from CSWM or Practice Improvement Manager (PIM)

19.1.7 Review the scope and remit of Junior Catch to ensure there is a protocol for prioritising allocation of cases (according to need and assessed risk / vulnerability rather than case type) and the role of Junior CATCH role in assessment is clearly defined.

19.1.8 Formulate and carry out a plan to ensure that social workers routinely consider and incorporate family history as part of Child & Family Assessments

19.2 Thames Valley Police

19.2.1 Thames Valley Police to remind officers that everyday policing decisions, including risk assessments, should be made using the National Decision Model and provide an example of how this should look when recording rationales in URNs/NICHE occurrences

19.2.2 Thames Valley Police to ensure their front line staff (including intelligence staff) are competent in their role in identifying the needs of children and any risk factors at an early stage and sharing this information in a timely and effective manner. This should include reference to the 2015 advice issued to the police by the Home Office and College of Policing entitled ‘Early Intervention: a guide for frontline police officers and PCSOs

19.2.3 Thames Valley Police to ensure staff are routinely conducting research into parents, children and unborn children in order to provide a full picture in relation to any risk factors. Where there are concerns then a ‘Child Protection – non-crime incident’ should be created for referral to the Multi-Agency Safeguarding Hub

19.2.4 Thames Valley Police to ensure PEC Operator understanding of question 6 within the missing/absent risk assessment. This question relates to the absent person as the victim of crime and not the perpetrator

19.2.5 Thames Valley Police to remind staff that, in the event of a strategy meeting being delayed, investigative considerations must be documented and action must be taken to expedite evidence gathering. If the investigation is not commenced immediately, the rationale must be recorded within the Niche OEL or policy log

19.2.6 Thames Valley Police to consult with relevant practitioners within the MASH and Referral Centres to ascertain the general status attributed to the initial discussion between police and social care following a new referral. Is this considered to be a strategy discussion? If so, how is this formally recorded? The end result of this consultation should provide practitioners with clear guidance in this area

19.3 Buckinghamshire Healthcare NHS Trust (Acute Services)

19.3.1 Accident and Emergency department and the Radiology department to review the Trusts Non Accidental Injury (NAI) imaging policy with the current national legislation and research to determine whether a skeletal survey should routinely to be completed on all children under 1year old who attend with a skull fracture.

19.3.2 The Safeguarding Lead and Lead Named Nurse to review the safeguarding children's training and compliance ensuring all staff have the correct level of training expected of them. To review the quality of the training packages, ensuring that staff are given effective training on documentation.

19.3.3 Lead Nurse for Paediatric services to review the Hospital's Nursing Policy for discharge of children

19.3.4 Safeguarding Lead and Lead Named Nurse for Safeguarding Children to review the child protection policy. To be reviewed and updated to reflect current practice and legislation. This policy must then be disseminated to all Trust staff

19.3.5 A Task and Finish group in conjunction with BSCB on updating and developing a policy on Bruising in any Child not independently mobile

19.4 Buckinghamshire Healthcare NHS Trust (Maternity)

19.4.1 The importance of documenting 28 week maternity assessments will be highlighted to all midwives

19.4.2 Information concerning support agencies to be circulated to all community midwives

19.4.3 All postnatal care plans are to be available following discharge from community midwifery team

19.5 Buckinghamshire Healthcare NHS Trust (Health Visiting)

19.5.1 Operational Lead for School Nursing to give clarity in terms of what service School Nurses offer to young people/children who are not accessing education but are deemed to be vulnerable

19.5.2 Named Nurses for child protection to ensure that all health visiting staff and school nurses are updated or trained to use the DASH tool

19.6 Youth Offending Service

19.6.1 Devise a standard template for all young people who are going to become a parent, who are already a parent, or who have caring responsibilities for young children. This will include:

- An assessment of parenting capacity taking into account a young person's risk and vulnerabilities
- A list of agencies that are working with the young person and how they communicate

- A plan of how and when information is shared
- A section for management oversight

19.7 General Practitioners (GPs)

19.7.1 GPs to do some routine antenatal care as per the local guidelines

19.7.2 Pro-active follow up of domestic incident reports. CCG good practice guideline to be reviewed

19.7.3 Vulnerable family meetings to be held in surgeries

19.7.4 Improve knowledge of GPs about the importance of early help for vulnerable families

19.7.5 Surgery 1 will discuss this case in depth at a learning event