Serious Case Review

EXECUTIVE SUMMARY

Services provided for Baby C and members of his family during the period June 2010 – October 2011

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Serious Case Review Overview Report Author — Keith Ibbetson

Identifiable dates have been removed, information relating to previous addresses has been removed, and all children are reported as male, irrespective of their true gender.

1 Background to the SCR and the reasons for carrying it out

1.1 Between December 2011 and May 2012 Buckinghamshire Safeguarding Children Board (LSCB) conducted a Serious Case Review (SCR) of the services provided to an infant who is referred to as Baby C and his two older siblings (Child D and Child E). Baby C died as a result of a head injury. The provisional post mortem finding was that the head injury was likely to have been caused by shaking. The post mortem also discovered that Baby C had suffered other fractures in the weeks prior to his death. The post mortem findings indicated that the explanations given by Baby C's parents did not satisfactorily account for the injuries that he had sustained.

1.2 The parents of all three children are a couple who are both in their late 20s of white UK origin. They are not believed to have other children. The surviving children in the family are currently, at the time of writing this report, the subject of care proceedings.

1.3 The SCR was carried out in order to fulfil the requirements of Chapter 8 of the statutory guidance *Working Together to Safeguard Children* [1] and the Buckinghamshire LSCB procedures. [2] The LSCB is required to conduct a SCR when a child has died and abuse or neglect is suspected to be a factor in the death. The findings of the post-mortem enquiry indicated that this was so. The children had lived with their parents in Buckinghamshire since mid-2010. It therefore fell to the Buckinghamshire Safeguarding Children Board to undertake the SCR.

1.4 The decision to hold the SCR was made by the Independent Chair of the LSCB on 7 November 2011. The review covers the period from mid-2010 (when the family moved to Buckinghamshire) until the admission of Baby C to hospital following the injury that caused his death in October 2011. The SCR also gave careful consideration to historical information about the contact agencies had had with the family before they moved to Buckinghamshire.

1.5 Prior to the death of Baby C there had been no significant child protection or welfare concerns about any of the children. Nevertheless the SCR was conducted in order to establish whether any indicators of risk had been overlooked by professionals and to establish whether – regardless of the death of Baby C – the history pointed to wider

[1] HM Government, *Working Together to Safeguard Children – 2010.*
[2] http://www.bucks-lscb.org.uk/sites/default/files/Procedures/Serious_Case_Reviews_January_2008.pdf

lessons that could be learnt or opportunities to improve services to safeguard and promote the welfare of children.

1.6 The findings of the SCR and the multi-agency action plan were accepted by the LSCB at its meeting on 15 May 2012. This is the Executive Summary of the findings. The SCR overview report has also been published. No individuals are identified in the published documents and information that could have led to the identification of the children or could lead to an unnecessary intrusion into the privacy of the other children in the family has been removed from the published version of the full report.

2 Arrangements for the SCR

2.1 The SCR reviewed the work of the following agencies who were involved with the family during the period under review. All are based in Buckinghamshire or are linked to the LSCB because they provide a significant range of services to children and young people in the county:

- Buckinghamshire County Council Early Years and Childcare Service (in relation to a nursery attended by Child D, Baby C's eldest sibling)
- Buckinghamshire Healthcare NHS Trust (which provided the health visiting, antenatal and midwifery service)
- NHS General practice and primary care (covering the services provided by two GP practices)
- Barnardo's (which operates a number of children's centres in Buckinghamshire)
- Paradigm Housing Group (a social housing provider which also undertakes homelessness inquiries on behalf of the District Council where the family lived)

2.2 Oxford Health NHS Foundation Trust (which provides mental health services in Buckinghamshire) provided a report providing the detail of a GP referral and one telephone screening interview with the mother of Baby C. The SCR panel decided that this gave a sufficient account of the contact with the agency and that an individual management review was not required.

2.3 The following agencies based in or covering the area the family previously lived in provided summaries of information about their contacts with the family:

- Police Service for the area they previously lived in
- Council for the area they previously lived in
    - Children's social care
    - Safer Communities (particularly the Anti-Social Behaviour Unit)

    - Housing Department
    - Sure Start / Children's Centre
- Community Health Services
- GP and primary care services

2.4 The SCR carefully scrutinised this information. It decided that there had been no significant concerns about the children before they moved to Buckinghamshire and that there were no significant gaps in the information that was shared with Buckinghamshire.

2.5 No faith, voluntary or community groups were identified as having been involved.

2.6 The review was conducted by a SCR panel which included senior representatives of LSCB member agencies who have expertise in safeguarding children and detailed working knowledge of the professional standards relevant to all of the services involved. The SCR panel was chaired by the Independent Chair of the LSCB. The SCR overview report was prepared on behalf of the LSCB by Keith Ibbetson. Both the SCR panel chair and the report author are independent of the agencies involved and have expertise in children's safeguarding and substantial experience in conducting Serious Case Reviews. The other members of the SCR panel were:

Organisation	Designation
Buckinghamshire County Council	Divisional Manager: Prevention, Assessment and Protection
Buckinghamshire County Council	Group Solicitor – Childcare, Legal and Democratic Services
Public Health Directorate – Buckinghamshire PCT	Head of Quality Improvement
NHS Buckinghamshire	Designated Nurse for Child Protection
Buckinghamshire County Council	Team Manager – Safeguarding in Education
Buckinghamshire County Council	Inclusion Manager – Early Years and Childcare
LSCB	Business Manager – SCR Project Manager

The work of the SCR panel was supported by the Buckinghamshire Safeguarding Children Board Manager and the LSCB Administrator. A health overview report was prepared by the Designated Doctor for Safeguarding on behalf of NHS Buckinghamshire which commissioned the health services involved with the family.

2.7 The purpose of the SCR is set out in *Working Together* as follows:

- to draw together a full picture of the services provided for the children and their family
- to establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- to identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- to improve intra-agency and inter-agency working and better safeguard and promote the welfare of children

2.8 Given the specific circumstances of the case the terms of reference of the SCR asked it to consider whether lessons could be learnt in the following areas:

- Relevant family history available to agencies pre-dating the period subject to detailed review
- The assessments undertaken and their quality
- Whether any risk factors were identified in relation to the children
- To establish to what extent professionals were aware of and took account of environmental factors in the assessment of the needs and strengths of this family
- Whether plans addressed any risk factors identified in the assessments and whether those plans were implemented
- How agencies shared information and involved other professionals or agencies to achieve the best outcomes for the children
- How far agencies focused on the needs of the Baby C and the other children in the family and took account of their experience in the family
- Factors which enhanced or impeded working relationships with the parents
- How the parenting capacity of the parents was considered and addressed
- Whether needs arising from ethnicity, religion, disability or any matter associated with social exclusion were identified and addressed

- Matters related to capacity, staffing and resources within agencies that impacted on the quality of the services provided
- To establish if staff involved had the skills, knowledge and experience to provide appropriate services to the family
- Whether individual agency and multi-agency policies were adhered to and to comment on the adequacy of those policies
- To establish if staff directly involved had appropriate supervision and managerial guidance

Given the circumstances of the death of Baby C the terms of reference asked the SCR to consider whether his death could have been prevented.

3 Family involvement in the SCR

3.1 Attempts have been made to engage with the family to seek their views about the services provided. They have chosen not to contribute to the review.

4 Key events in the case history

4.1 There had been relatively little agency contact with Baby C and the–other family members of his family. This is because until the admission of Baby C to hospital with the injury that caused his death there had been no cause for professionals to believe that any of the children was at risk of significant harm. There was no police or social care involvement with the family during the 16 month period in which they lived in Buckinghamshire.

Contact with agencies before their move to Buckinghamshire

4.2 Before they moved to Buckinghamshire, the family experienced the sort of difficulties that are common to many families. In 2005, before she had children, the mother was recorded as having suffered domestic abuse. The perpetrator was a previous partner, not the father of these children. This led to brief police and social care involvement. The mother presented to the maternity services at a late point during both of her pregnancies (at 26 and 24 weeks) and she suffered from mild post natal depression. Despite the possible implications of these aspects of the history there is no subsequent record of any concerns about the care or development of the children during the pregnancy, at birth or in their early years. The children had contact with GPs and health visitors and were also taken to a children's centre. The overall perception of the professionals who

had contact with the children was that both parents were engaged in their care and that the children were well cared for.

4.3 During this period the family did not find it easy to find suitable housing and moved home several times. There was evidence of conflict with neighbours which triggered their move out to Buckinghamshire. It is not clear why the family moved to Buckinghamshire in particular as there is no evidence of family links with the area. The family moved to Buckinghamshire in a hurried way and this meant that a number of the services in in the original area did not know that they had moved to Buckinghamshire. However there was no specific reason for these professionals to have referred the family for additional support because the concerns that there had been about the family in that area were either historic or had been satisfactorily resolved by the time the family left.

Contact with agencies in Buckinghamshire prior to the birth of Baby C

4.4 On arrival in Buckinghamshire the family presented as homeless and were temporarily housed in shared hostel accommodation pending investigation of their circumstances. They remained in this accommodation for approximately 6 months before being offered their own home. During this period the family complained of noise nuisance from neighbours and there were two minor fires in the shared accommodation with led to a brief temporary move. The mother said that this, together with the family's unplanned move, led her to experience some anxiety and panic attacks. She stated that these were a recurrence of a problem that she said she had experienced periodically since childhood. The mother sought help from her GP who made a referral to the mental health trust. The mother had telephone contact with the mental health support service and received advice and literature, but she did not follow up the opportunities for further contact offered.

4.5 During this period the family had frequent face to face and phone contact with a health visitor who provided a range of practical support as well as monitoring the health and development of the children. Contact was offered by a children's centre but not taken up. The health visitor assessed the children as being 'vulnerable' and in need of additional support because of the way in which they had had to move and because there were minor concerns about their development and behaviour. However there were no indicators of any risk of significant harm or poor parenting.

4.6 After the family moved to their own accommodation the parents reported being much happier and more settled. The mother presented for antenatal care in early 2011. On

this occasion she was a few weeks pregnant. Because of her own medical condition she was identified as being in need of consultant led antenatal care, with clinic attendance mainly at a local hospital.

4.7 In March 2011 a health visitor based in the locality where the family now lived undertook a full family health needs assessment. Her assessment was that the family were no longer in need of targeted additional services based on the family's own account of their improved circumstances and her own assessment that Child D and Child E were developing well and meeting expected milestones. Practical support continued to be made available to the parents by the health visitor and a children's centre, though once more the family did not take up offers to attend.

4.8 In early 2011 Child D (the eldest child in the family) began to attend a part time nursery place. His parents were perceived as looking after him well having friendly relationships with other parents. No concerns were ever expressed or recorded about the children or family at this nursery. The nursery noted mother's concerns about Child D having a problem toilet training at home and advised her about this. They were within normal developmental bounds and never considered this to be a significant issue, although the mother was anxious about it. Later the health visitor offered advice on this and the GP made referrals for specialist input. The parents followed the advice given.

4.9 During her pregnancy the mother attended at the hospital for her scan and one consultant appointment, however she subsequently missed three hospital antenatal checks. The reasons given for this were illness in the family and difficulties with transport. The mother attended local clinic and GP appointments arranged instead and there were no difficulties with the pregnancy. Baby C was born during a planned admission in mid 2011.

Professional contact during Baby C's life

4.10 During the first six weeks of his life Baby C was seen on eight occasions by the community midwives, the family health visitor and a community nursery nurse (part of the health visiting team). The only concern identified about his health and development was that he was gaining weight more slowly than would normally be expected. As a result increased monitoring was undertaken by the health visitor who gave the parents additional, tailored advice on feeding. The health visitor did not discuss her concerns about slow weight gain with the family GP. She was not able to monitor Baby C's weight and growth during the last three weeks of his life because at that point the family did not take her phone calls or keep appointments. Prior to this the parents had cooperated fully

with the health visitor and the reasons for the change in their behaviour cannot be established with certainty.

4.11 The last professional contact with Baby C was in early October 2011, more than three weeks before he was admitted to hospital with the injury that caused his death. Based on the information available from the post mortem examination it is now understood that during this period Baby C received injuries most likely to be the result of another assault. There is currently no further information about this. No professional was in contact with the family at this time or in a position to identify any signs or symptoms of abuse.

4.12 At some point shortly before his admission to hospital with a serious head injury it is believed that Baby C was assaulted. There is no further information available which would explain why or how this happened. The SCR notes research indicating that shaking injuries are sometimes known to occur as a result of a one off loss of control in families where there has been no previous concern about the care of children. This can happen as a response to a child crying in a way that a parent finds distressing and difficult to understand. [3]

5 Conclusions of the SCR and key lessons learnt

5.1 In his review of services to safeguard children in England in March 2009 Lord Laming recognised that not every child death resulting from abuse can be prevented, noting that some deaths arise from '*the sudden and unpredictable outburst by an adult towards a child*'. He notes that such circumstances are '*entirely different from the failure to protect a child or young person already identified as being in danger of deliberate harm'*. [4] The circumstances that led to the death of Baby C remain unknown but may fall into this category. It follows that in such cases services to safeguard children may not have had any indication that the child was at risk of death or serious harm.

5.2 Although his parents had experienced some instability and difficulty in their lives, for the most part the parents of Baby C brought up their children without the need for significant additional services. Taking the history as a whole there is no evidence of any significant concerns identified in relation to the health or development of the children or the care that their parents provided for them. There were no risk factors pointing to a significant risk to the safety of Baby C and there was no indication

[3] http://www.nspcc.org.uk/inform/resourcesforprofessionals/underones/preventing_nahi_wda85611.html
[4] The Lord Laming (March 2009), *The Protection of Children in England – a Progress Report.,* HC330 Stationery Office

whatsoever that he might be at risk of suffering the type of severe injuries that are believed to have caused his death.

5.3 The professionals who were in contact with the family made available a range of family support services which they believed were in line with the practical health and social problems that the family were experiencing. The work of professionals was focused on the needs of the children. The assessments undertaken and the plans made for the children were in accordance with their needs as professionals could best understand them.

5.4 The professionals who had contact with the family were experienced and well trained. Although there was never any need for the case to be brought to the attention of supervisors or more senior staff the evidence is that staff involved with the family were properly managed and supervised. There is no indication that any lack of resources adversely affected the services provided.

5.5 It may be that this was a family that could have benefitted from a greater degree of support and intervention, but there is no evidence at the time that this was needed or would have been justified on the basis of the information that was apparent to professionals. This was the view of the professionals involved with the family and having undertaken a detailed review of the actions and decisions of professionals through the SCR this is also the judgement of the LSCB.

5.6 There are wider lessons to be learnt from the SCR which has highlighted valuable learning about the way in which health staff collaborate in order to provide services in the antenatal period and for infants under the age of 12 months. Recent research based on an overview of the findings of SCRs has underlined the vulnerability of infants under the age of 12 months.[5] Health professionals are often the only ones actively working with these children and their families.

5.7 In this case there were points in the case history when professionals missed opportunities to coordinate aspects of health provision because they did not routinely consider that it would have been valuable for information about the family and about the action that they were taking to be shared with colleagues. This learning relates to midwives, health visitors and GPs. These missed opportunities should be considered as lessons learnt which highlight possible ways in which services can be improved.

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[5] Ofsted (2011) *Ages of concern: learning lessons from serious case reviews - A thematic report of Ofsted's evaluation of serious case reviews from 1 April 2007 to 31 March 2011*

They did not adversely affect family members and nor did they have an impact on the outcome for Baby C.

5.8 There are specific lessons to be learnt from the response of the health visitor to the slow weight gain of Baby C and the use of centile growth charts to plot and monitor this aspect of children's health and development. Considered superficially the task of weighing a baby, plotting his weight and interpreting his growth might appear to be straight-forward. This case history shows that in reality gathering, recording and interpreting this information and deciding what action to take is a complex task where knowledge and professional judgement need to be combined with clear guidance, support and training for staff. This is particularly so when health professionals are dealing with changes in the pattern of weight gain in a very small infant over a short period of time rather than with an obvious long term trend. The SCR found that the guidance and training provided to staff who undertake this work could be improved and recommendations have been made in relation to this.

5.9 The SCR overview report has also identified findings in the following areas pointing to the need for recommendations which should lead to improvements in services:

- Arrangements for identification and review of vulnerable families in GP surgeries
- Promotion of better liaison and working arrangements between Health Visitors, GPs and other members of primary health teams
- The need to promote a better understanding of the legitimate role of health visitors and their teams in dealing with early childhood developmental and behavioural problems
- Better use of the antenatal liaison form to ensure that there is more comprehensive sharing of information between antenatal services, GPs and Health Visitors
- Improving the knowledge that midwives have of relevant history from women's previous pregnancies
- The need for a consistent national approach to the recording of responses to confidential questioning during pregnancy about domestic violence
- Improvements in the completion of information (including children's weight) by midwives in Personal Child Health Records
- Checking the effectiveness of social care review intake and referral arrangements in relation to the recording of notifications and enquiries where details of the family are not provided

- Review of the guidance and training provided on the use of growth charts in relation to very young infants

6 Learning the lessons of the SCR and the implementation of recommendations

6.1 The findings of the SCR and the recommendations that flow from them have been adopted by Buckinghamshire LSCB and the member agencies directly involved. The LSCB has produced an action plan that sets out the actions needed to implement the recommendations, identifies who is to be responsible for taking them and the timescales for completion. Many of these recommendations have already been fully or partly implemented.

INDIVIDUAL MANAGEMENT REVIEW RECOMMENDATIONS

Barnardo's Children's Centres

1. In all cases where additional support is being provided to a family and where outreach work has not been agreed or allocated, a pre-assessment checklist (or equivalent) must be undertaken.

2. In all cases, where additional support is being provided to a family and where outreach work has not been agreed or allocated, the worker must first of all discuss their proposed actions with their line manager, and bring such actions for discussion in supervision sessions.

3. In all cases where a home visit is being undertaken, for whatever reason, a risk assessment should be undertaken in advance, seeking advice and information from partner agencies as appropriate.

Paradigm Housing Group

1. Further training for PHG housing management front line staff, focussing on practical examples and case scenarios.

2. Paradigm Maintenance Limited front line operatives and their managers to undertake Safeguarding Children, Young People and Adults training.

Buckinghamshire Healthcare NHS Trust (Health Visitors)

1. The Health Trust to review the process for how staff respond to 'no access' visits or telephone contacts in terms of what is expected and at what stage do they escalate any concerns and to whom.

2. The Health Trust to re affirm the importance of clinical supervision for all practitioners & ensure that the organisation continues to support the implementation of regular clinical supervision.

3. The Health Visitor Team Lead to review the method & frequency of communication between the two GP Practices & HV Teams involved with the family.

4. The Health Trust to improve effectiveness of the current documentation with regard to capturing the voice of the child, role of the Father, analysis of information & the rationale for the planned intervention by the practitioner & incorporate this into the new electronic record system.

5. The Health Trust to develop the use of the ante natal liaison tool, which is currently being piloted across the Trust.

   Universal ante natal contact by the health visitor will be phased in across the Trust.

6. To ensure the local guidelines regarding the growth of children are more specific and are not open to misinterpretation

Buckinghamshire Healthcare NHS Trust (Maternity Services)

1. Develop the communication process between the Midwifery Service and the Health visiting Service currently being piloted.

2. To consider the need for specific training pertinent to Confidential Routine Enquiry.

3. To consult Perinatal Institute amending the national pregnancy notes regarding a specific section for domestic abuse.

4. To review the current process for recording the outcome of Confidential Routine Enquiry.

Health Overview Report

1. NHS Buckinghamshire to promote better liaison and working arrangements between HV, GPs and other members of primary health teams

2. NHS Buckinghamshire to disseminate promote a model of identification and review of vulnerable families in other surgeries based on the model that has been developed in GP surgery 2

3. Buckinghamshire Healthcare Trust to review its process of antenatal and postnatal information sharing between midwives, health visitors and GPs.

Serious Case Review Overview Report

1. BCC should check the current functioning of its referral & assessment arrangements to ensure that the system for recording notifications & enquiries to the authority where the family is not identified is working effectively.

2. Health commissioners and Buckinghamshire healthcare NHS Trust should consider jointly how to promote a better understanding of the role of health visitors and their teams in dealing with early childhood behaviour and developmental problems.

3. The LSCB should ensure that agencies make professionals aware of the need to reflect on significant changes in parental behaviour (including withdrawal of cooperation & contact), especially where there are grounds to suspect a risk of significant harm.

4. CONTINGENCY: If legal findings point to the shaking of Baby C as a likely explanation for his death, then the LSCB should consider the need for a publicity campaign to raise awareness of the dangers of shaking babies.