Serious Case Review

Redacted Overview Report

Services provided for Baby C and members of his family from June 2010 until October 2011

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This report has been redacted to remove information that may identify family members. 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.

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1 ARRANGEMENTS FOR CONDUCTING THE SERIOUS CASE REVIEW

Introduction

1.1 This report was prepared for Buckinghamshire Local Safeguarding Children Board (the LSCB) in order to fulfil the requirements of Chapter 8 of the *Working Together* guidance. [1] This statutory guidance sets out the arrangements for the local interagency review of cases which have given rise to potential concerns about the safeguarding of children and where there may be important lessons for the local network of agencies with child protection responsibilities. This document is the LSCB overview report on the Serious Case Review (SCR). It summarises and complements the findings of the individual management reviews conducted by the agencies that provided services. The report presents the findings of the SCR conducted by the LSCB with the objective of improving local child protection practice.

1.2 The detailed current arrangements for review of such serious cases by LSCBs in Buckinghamshire Local Safeguarding Board Procedures. [2] These procedures reflect national guidance and in the conduct of the SCR the LSCB has sought to comply fully with the statutory guidance published on 1 April 2010. The SCR also takes account of further guidance relating to the publication of SCRs circulated in June 2010.

1.3 The SCR concerns three children: (redacted)

1.4 At the point of concluding the serious case review very little definite information has been established about the events that led to the injury that caused the death of Baby C, which are the subject of a continuing police investigation and medical enquiries. The full post mortem report is still awaited. (redacted) The provisional post mortem finding is that the head injury is likely to have been caused by shaking and the explanation given by Baby C's parents as to how the injuries were caused does not account for all of the injuries that were apparent at the time of presentation to hospital. At the post mortem enquiry it was discovered that Baby C had suffered other fractures. The best medical opinion that can be currently given is that these other fractures occurred approximately 2 weeks before the death of Baby C. It is unlikely that any more precise dating of these injuries will become available.

[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

Despite the uncertainty as to their cause and timing the presence of these injuries does suggest that Baby C experienced more than one traumatic episode. (redacted) The parents have been questioned by the police about the earlier injuries and have not so far given an account of them.

The scope, focus and terms of reference of the Serious Case Review bearing in mind the circumstances of the death of Baby C and the involvement of agencies

1.5 *Working Together* states that the LSCB in the area where the child normally lived should conduct a SCR when a child has died and '*abuse or neglect is known or suspected to be a factor in the death'.* The circumstances of Baby C's death fit this criterion. Buckinghamshire LSCB therefore decided to conduct a SCR. In reaching the decision the LSCB was aware that there had been relatively little involvement of agencies with safeguarding responsibilities with the family. Nevertheless the SCR is required in order that the LSCB and individual member agencies could evaluate in detail the services that had been provided for the family, determine whether any indicators of risk or need had been missed and identify any possible opportunities for service improvement, even though there might be no link between the actions and decisions of professionals and the death of Baby C.

1.6 The recommendation to hold the SCR was made at the meeting of the LSCB Serious Case Review sub-group on 2 November 2011 and the decision was confirmed by the Independent Chair of LSCB on 7 November. Work began at that point to agree the scope and terms of reference of the review. Following these early discussions, formal notifications of the review and the methodology for its conduct were sent to all Buckinghamshire LSCB member agencies. Through a review of agency records the LSCB determined which agencies should contribute Individual Management Reviews. A full list of the agencies involved in the review is set out in section 1.12 below.

1.7 The LSCB in (redacted) has been informed about the decision to conduct the SCR and has cooperated fully and promptly with requests for background information about the family. (redacted) LSCB was kept informed about the progress of the review and invited to attend the SCR panel for a discussion of the SCR overview report. (redacted) agencies have made recommendations arising from their involvement. This level of cooperation and involvement was agreed to be appropriate given the circumstances of the case, particularly noting that Baby C was born some months after the family moved from

(redacted) and that agencies in (redacted) had only limited involvement with the family prior to their move. Paragraph 1.14 provides further information on this.

1.8 The *Working Together* guidance makes the LSCB responsible for determining the scope and terms of reference for the SCR taking into account the circumstances of the particular case. Consideration was given to this within the SCR panel and there was also consultation with participating agencies. The general terms of reference for the SCR adhere to the objectives for SCRs set out in the *Working Together to Safeguard Children 2010:*

- to draw together a full picture of the services provided
- to establish whether there are lessons to be learned from a case about the way in which local professionals and agencies work together to safeguard children
- to identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result, and hence improve interagency working and better safeguard children

1.9 The specific terms of reference agreed for this review are set reproduced as Appendix 1 to this report. The terms of reference address issues identified in *Working Together to Safeguard Children 2010* as being of general relevance and also issues specific to the case history. The terms of reference were followed by the authors of individual management reviews. They have also been followed by the author of this overview report. The SCR overview report provides a chronological account of agency involvement with the family and then focuses on the following questions and themes which are evaluated in detail in Section 4:

- 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

The findings in relation to the terms of reference are addressed throughout section 4 of this report.

1.10 The overview report also makes recommendations on changes required to implement the learning from the SCR. These take account of the recommendations contained in individual management reviews and developments in services that have occurred since the events in question took place. The SCR either makes recommendations on matters that are not already part of the work programme of individual agencies and the LSCB, or in some matters it makes recommendations to strengthen work that is already taking place.

Critical periods of agency involvement covered by the SCR

1.11 Baby C was born in mid 2011. His mother began to receive antenatal care in relation to this pregnancy in early 2011. The LSCB decided that the scope of the SCR should cover the entire period when the family had lived in Buckinghamshire. It was also agreed that it would take into account any significant background information arising from the period when the family lived in (redacted) and also consider whether relevant information about the family's life in (redacted) was known to agencies in Buckinghamshire.

Agencies involved

1.12 The following agencies and contracted professionals provided services to the children and to other family members within the period covered by the review and have been evaluated within individual management reviews:

- 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 service, antenatal and midwifery services)
- 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)

1.13 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.

1.14 The following agencies provided brief background information about their contacts with the family in (redacted) in response to a template provided by Buckinghamshire LSCB:

- (redacted) Police Service
- (redacted) Council
    - Children's social care
    - Safer Communities (particularly the Anti-Social Behaviour Unit)
    - Housing Department
    - Sure Start / Children's Centre
- (redacted) Community Health Services
- GP and primary care services

1.15 No faith, voluntary or community groups were identified as having been involved, either in (redacted) or Buckinghamshire.

1.16 The SCR panel and the overview author have both carefully scrutinised the information available from agencies in (redacted). The shared judgement of

the panel and the overview report author was that there had been no significant concerns about the children in (redacted) and that there were no significant gaps in the information that was shared between (redacted) and Buckinghamshire when the family moved, given the nature of the contact that agencies in (redacted) had had with the family. As a result it was decided that there were no grounds for the scope of the review to be extended to cover a longer period to evaluate events in (redacted) or for the review to be conducted jointly with (redacted) LSCB.

1.17 The background information from (redacted) LSCB has identified possible shortcomings in some of the services provided there, though these do not relate to any serious risk to the children and it is the judgement of the panel that they have no bearing on the death of Baby C. The SCR has recommended that (redacted) LSCB should make further local enquiries in relation to these matters and make any recommendations that it believes are necessary.

1.18 The *Working Together* guidance stipulates that a health overview report should be prepared on behalf of the commissioning Primary Care Trust (now NHS cluster). The purpose of the report is to provide an overview of health provision and to identify findings from the SCR which have implications for the commissioning of health services. The Designated Nurse and Doctor for Safeguarding for NHS Buckinghamshire worked together to prepare this report. The findings of the health overview are significant in this case because the vast majority of contacts with this family were made by health agencies. The findings of the health overview report have contributed to the findings of this SCR overview report.

Availability of records

1.19 With the following exception all of the relevant records have been available in order to conduct this review. Health agency records and interviews with staff indicate that on two occasions enquiries were made with Buckinghamshire County Council social care staff in order to establish if the family were known. There are no written records of these enquiries in the local authority. This is not viewed as being of any significance in relation to the provision made to Baby C and his family or to the death of Baby C. However a recommendation

has been made in relation to the recording of enquiries of this nature under social care referral and assessment arrangements.

1.20 There are a number of minor discrepancies between records held in different agencies. These are highlighted either in the narrative or in the evaluation in section 4 of this report. There is no evidence that these discrepancies are significant. There are also a number of points where it is not possible to track with complete confidence the full details of services provided to the family. These largely relate to diagnosis and treatment of a long standing medical condition of the mother. There is no evidence that this condition has any direct bearing on the death of Baby C. The SCR has also identified a number of points in the chronology when the mother provided false or exaggerated information about the family's circumstances which are not corroborated by agency records. This is explored in section 4.5 below.

Appointment of the SCR panel, the SCR panel chair and the appointment and role of the independent overview report author

1.21 A full list of the roles and professional work titles of SCR panel members is contained in Appendix 2 of this report. SCR panel members are senior managers in member agencies or designated / specialist professionals with substantial experience of safeguarding children.

1.22 The SCR panel was chaired by Donald McPhail, who is also the Independent Chair of Buckinghamshire LSCB. This arrangement is consistent with the statutory guidance. He is not employed by any of the agencies involved in the review. He has substantial experience and expertise in child protection services and in the conduct of SCRs.

1.23 The SCR overview report was prepared by Keith Ibbetson. He has no relationship of any kind with any of the agencies involved in the review or to anyone involved in the case or the SCR. He has not previously been employed by Buckinghamshire LSCB. He is an experienced author of SCRs and chair of SCR panels. The independent author has not been a decision making member of the SCR panel but has taken the following roles:

- to attend meetings of the SCR panel and provide professional advice as required
- to review the agency management reviews and to seek out and evaluate along with the SCR panel additional relevant material to corroborate or develop the findings made by agencies

- to assist the panel in improving the quality of the agency management reviews
- to prepare the overview report on behalf of the panel and finalise it following panel discussion
- to prepare the executive summary on behalf of the LSCB

1.24 Since the decision to hold the review the SCR panel has met on 9 occasions in order to:

- make decisions on the conduct of the review
- manage the review so as to ensure that it complied with the statutory guidance
- consider progress in the production of agency management reviews and chronologies
- receive and consider an initial draft of this overview report and of the health overview report
- to decide when and how it would be best to engage members of the family in the review
- to consider and agree recommendations
- to consider a draft action plan
- to agree the overview report, the recommendations and action plan and to agree the executive summary for recommendation to the LSCB

Quality of individual management reviews and steps taken to improve their quality

1.25 The SCR panel and the overview report writer have scrutinised the quality of the IMRs to ensure that they provide a full and objective evaluation of the work of each agency. Most review writers were asked to clarify points of detail in their reports. Feedback has been provided to the agencies responsible in order to improve the quality of the reports and to monitor the implementation of recommendations while the review was under way. There has been a high level of cooperation in that process and support from all of the participating agencies. All of the individual reviews have made an important contribution to the findings of the SCR.

Parallel processes that have impacted on the conduct of the SCR

1.26 Thames Valley Police is conducting the criminal investigation into Baby C's death. The SCR panel and the overview author have received updates on the

progress of police enquiries. The overview report author has read information gathered during the criminal investigation which had been disclosed to the local authority and to other parties in the care proceedings that are being undertaken by the local authority in relation to the two surviving children in the family. This sharing of information enabled the SCR panel and the independent overview report author to feel confident that the review can take account of any additional significant information that may not have been known to agencies before the death of Baby C. (redacted)

1.27 The criminal investigation is likely to be lengthy because of the nature of the injuries which Baby C suffered and the need for specialist medical opinion on them. The future progress of the criminal investigation will be the subject of detailed discussions between the police and the Crown Prosecution Service, given the nature of Baby C's injuries and the circumstances of the death. At the point when the SCR is concluded the criminal investigation will still be incomplete. The LSCB recognises that additional information may come to light as further enquiries and investigations are undertaken. Prior to the publication of any material in relation to the SCR findings the LSCB will therefore review all of the findings of the SCR in the light of any new information arising from criminal or medical investigations.

Involvement of family members

1.28 The mother and father of Baby C were informed in writing that the SCR had been initiated and additional information about the review and support were offered via the family's allocated social worker. The SCR panel has discussed in detail how best to involve family members in the review in order to include their perspective on the services that were provided. The consensus view of panel members and the overview report author is that given the specific circumstances of the case it would not be possible to do this at this stage without the risk of prejudicing the criminal investigations and any potential criminal trial. This is because in this case there is a significant overlap between the evidence that may be relevant to criminal proceedings and the areas which are of interest to the SCR.

1.29 This position will be kept under active review and it is hoped that after criminal proceedings are completed there will be an opportunity to discuss the case with involved family members. The LSCB has been asked to adopt this report on the basis that it is a full report of the lessons from the SCR at this point and

in the recognition that additional information may supplement the findings at a later date.

1.30 The position of members of the extended family was also considered. There was no agency contact with them during the period under review and they are only occasionally referred to in agency records. It was therefore agreed that they would not have information relevant to the purpose of the SCR.

Publication of the SCR Overview Report and Executive Summary

1.31 The guidance under which the SCR conducted its work provides for the SCR overview report to be published in full '*unless there are compelling reasons directly related to the welfare of any child directly concerned in the case for this not to happen'.*[3] No information may be published which risks undue intrusion into the privacy of family members, particularly the surviving children in the family.

1.32 No information about the review will be made public before the conclusion of any criminal proceedings related to the case in order to avoid potential prejudice. Final arrangements for the publication of the SCR overview report will be a matter for the Independent Chair of the LSCB in consultation with member agencies. The decisions reached will take full account of the circumstances at the time. Factors likely to inform this decision will be set out in explanatory information to be provided to Ofsted when the SCR materials are submitted for evaluation.

1.33 An Executive Summary will be published which sets out the circumstances of the case (without publishing anything that would risk identifying the children involved) and any lessons learnt by the SCR in full. The content of the final version of the executive summary will be finalised at the time of publication.

The action plan arising from the SCR

1.34 A comprehensive action plan has been prepared by the LSCB which includes a full account of the recommendations arising from the individual management reviews, the health overview report and from the SCR overview report. This includes comprehensive information about the recommendation and the actions being taken by agencies to implement them. Where action has already been taken to implement recommendations fully or in part this

[3] Letter of the Parliamentary Under Secretary of State for Education to LSCB Chairs and Directors of Children's Services, 10 June 2010

progress is noted. The action plan will be regularly monitored by the LSCB. At an appropriate point the LSCB will publish a full action plan showing the progress that has been made in the implementation of recommendations and any outstanding actions.

The papers constituting the SCR for submission to Ofsted

1.35 The SCR consists of the following reports and documents:

- The overview report
- The combined chronology of agency contacts
- The individual management reviews (and background reports from local agencies with very limited involvement)
- Background reports from agencies in (redacted)
- The integrated multi-agency action plan
- The draft executive summary

2 DETAILS OF FAMILY MEMBERS

(redacted)

2.1 Significant information emerging from the family history

2.1.1 So far no significant information has been identified in the history of either parent. There are references to grandparents playing a supportive role with the family in (redacted) when the mother suffered depression after the birth of her first child. However no detail is contained in the records.

2.1.2 It was recorded that the family chose to move to Buckinghamshire when they had to leave their home in (redacted) because they had family members in the area. There is no information in agency records about members of the extended family being involved with the children during this time. However this is not to say that there was no involvement. It may simply not have come to light given the relatively limited involvement of agencies with the family.

2.2 The experience and day to day lives of the children

2.2.1 As a result of the limited involvement of professionals with the family there is relatively little information about the day to day experience of the children. The following paragraphs summarise the limited observations that there are.

Child D

2.2.2 In Buckinghamshire Child D attended a local nursery for a half day session for six months prior to the death of his sibling. He attended regularly and the absences he had were explained by his parents. Information about the absences (largely due to normal childhood illnesses or events in the family) is not concerning and is corroborated by information held in other agency records. Child D seemed happy and was 'well turned out' according to staff. He made friends and his parents appear to have got on well with other parents. No concerns or indicators of potential risk were identified. On the contrary staff believed him to be well looked after. His mother had some anxiety about his toileting at home. Given his age the mother's account of the problem and his anxiety about it were not considered unusual. The parents were given advice about this.

2.2.3 Although the nursery was not aware of it, the mother sought additional support and advice from health visitors and GPs about Child D's toileting problem. This led to referrals being made to a paediatrician and then to a child psychiatrist. There is in fact nothing to suggest that this was any more

than a normal developmental problem and that the referrals reflect the anxiety of the mother and the keenness of the GP to help.

2.2.4 Child D received an overdue immunisation shortly before the death of his sibling. No concerns were noted about him.

2.2.5 Records from (redacted) on Child D record no concerns about his health or development and no adverse observations about the care he was receiving.

Child E

2.2.6 There is little detailed information about Child E's daily life and experience. There are no indications at all that professionals who had contact with him had any significant concern about him and such problems as there were about his health and development were minor and resolved themselves.

2.2.7 In August 2010 (when the family were living in temporary accommodation in Buckinghamshire) the mother reported Child E was unsettled, due to teething and that she felt unable soothe Child E. However the health visitor (HV1) observed what she felt were positive interactions between Child E and his mother. In October 2010 (redacted) the health visitor (HV1) assessed Child E's growth and development and gave the parents advice about Child E's sitting and balance. This appears to have been followed and by the time of the next significant contact in March 2011 his health and development were assessed as being normal.

Baby C

There were no concerns or negative observations about Baby C's birth or subsequent care. The only potentially significant concern relates to Baby C's slow weight gain during his life. This is described in detail in section 3 below and the response of the professionals who were aware of it is evaluated in section 4.5. Poor weight gain and nutrition were not identified as concerns at the post mortem examination of Baby C and were not associated in any way with the cause of his death.

3 Narrative of events and agency involvement with the family

Introduction

3.1.1 This section of the report provides details of the key events and the involvement that agencies had with the family. This is based on the comprehensive chronology of events compiled during the course of the SCR.

3.1.2 (redacted)

Key events and dates in Buckinghamshire prior to the antenatal care of Baby C. This includes the period June 2010 – January 2011

Date	Summary of key event
25.6.2010	The mother and father presented to the Paradigm Housing office in Chesham. Paradigm acts as the agent for Chiltern District Council in assessing homelessness. At this point Paradigm states that a previous homelessness application being processed in (redacted) was discharged.
28.6.2010	The family were given temporary accommodation in a homeless hostel (redacted)
29.6.2010	Parents were seen at housing surgery and were advised to submit personal statements in order to support their housing application
14.7.2010	Health visitor (Bucks HV1) met the mother opportunistically as part of her routine visiting to the hostel. She recorded that the family had 'fled' to Bucks following violence in previous home and that they have extended family in this area. Bucks HV1 sought notes on the children from previous health visitor on 20.7.2010. The parents told the health visitor that both police and social care had been involved because of this incident. The police in (redacted) did notify social care of the incidents (via a (Redacted) notification) and may have told the family this. Information from (redacted) social care is that there was no involvement with the family for the reasons set out above. Health visiting records from (redacted) for Child D were received on 13.9.2011 and for Child E on 1.11.2011 after being chased on a number of occasions. The reasons for this delay are not known.
19.7.2010	Child E registered at Bucks GP surgery 1. The parents did not keep an appointment on 23.7.2010 (assumed to be an appointment for health checks associated with registration at the practice). The mother's notes were never seen at this GP surgery and were transferred directly to Bucks GP Surgery 2 on 10.3.2011
27.7.2010	HV3 saw the parents during the course of a visit to the homeless hostel. Father told the health visitor that his partner was anxious due to noise and violence at their previous (redacted) address
5.8.2010	Mother reported to Paradigm Housing that there was noise nuisance from a neighbour at their current accommodation and that both the father and Child E were suffering the effects of a recent fire

Date	Summary of key event
	in the homeless accommodation and would be seeing the GP. Checks have established that there were two fires in the hostel at this time, one in another flat and one in the grounds. These led to all the residents being temporarily rehoused because the hostel sprinkler system caused some damage to properties. There is no record of either the father or Child E being taken to the GP because of smoke inhalation.
9.8.2010	Mother reported to Bucks HV1 that Child E had been taken to the GP because of smoke inhalation. The GP chronology notes a related hospital attendance. Child E was due to have an immunisation at the GP surgery on 10.8.2010, but this did not happen at this point
17.8.2010	HV1 arranged a 'transfer in' visit the same day. The management review says that she did this because she had received a notification of GP registration pointing to the fact that the family would be staying long term in the area. The mother told her health visitor that there had been two recent fires at the hostel and that as a result Child D was very frightened. During the transfer in visit the mother stated that: • She had no money for nappies etc • She found it difficult to soothe Child E when he cried • The local children's centre had a waiting list • Child D had previously received help for 'head banging' but this was no longer necessary • Child E weighed 8.85kg • Child E described as having teething problems and mother asked for social work support as she had previously had There is no reference to Child E receiving help for 'head banging' in any agency record. Bucks HV1 states that she left a message with social care to see if support could be offered, but that it could not be in the circumstances. Social care has no record of this contact.
17.8.2010	HV1 spoke to the family's previous (redacted) health visitor on the phone. She said that the family had moved because of disturbances with neighbours, but so far as she was aware the family had not had contact with a social worker. Following this contact the health visitor spoke to the mother to indicate that if she felt support was required from social care she should initiate contact herself so that she would be able to say directly exactly what help she thought was needed. It is noted that the health visitor had not worked for long in the UK and so was not aware in detail of the role that social care would or would not play in providing practical and financial support. The health visitor also told the mother that (contrary to what the mother had stated) there was not a waiting list at the Children's Centre and that the health visitor would complete a referral for outreach services.

Date	Summary of key event
25.8.2010	HV1 made a prearranged visit, but the family was not in. Mother reported when followed up on 2 September 2010 that the family were staying in (Redacted) as a result of a further fire at the hostel.
17.9.2010	HV1 wrote to the mother to arrange a transfer in visit after three unsuccessful phone calls. She also sent the parents a list of local child care and family support resources that the family could access
30.9.2010	Mother attended GP surgery 1 in relation to her heart condition.
4.10.2010	HV1 was contacted by the Children's Centre to see if a referral had been made as the family had been in touch. The health visitor confirmed that it had been sent. The following day the mother contacted HV1 to see if she could obtain a buggy. The health visitor advised on possible local sources. Mother told her that her grandfather had recently died. A joint visit to the children's centre was arranged for 15.10.2010
6.10.2010	A buggy was supplied to family and mother was advised to check its safety. Mother sought support from HV1 in relation to the family housing application and a letter was sent to the housing service.
13.10.2010	Mother had her new patient registration check at GP Surgery 1. She referred to her heart condition and her unhappiness living in the hostel. The GP made a referral to 'Healthy Minds' (a tier one mental health service) because the mother reported suffering from 'panic attacks'. The mother later missed two further appointments at the GP in October and no family member had any further contact with general practice until the family registered at GP surgery 2 in February 2011.
15.10.2010	HV1 made a joint visit to the family home with a member of staff from a Children's Centre. The mother reported that she had seen her GP and that she: • Was stressed by her housing situation • Depressed but not suicidal • Had started anti-depressant medication • Was seeking numerous household items Child E was weighed at 10kg (91st centile) He was noted not yet to be sitting independently (redacted) and advice was given on this. The parents were found to be receptive to this. The mother was advised to keep up appointments with her GP in relation to her feelings of depression. There is no record of the GP prescribing anti-depressants. The parents were given information about drop-in sessions at the Children's Centre and there were follow up phone calls to update them about services, but they never attended this centre.
20.10.2010	The mental health trust received referral from GP1 noting that the mother had been '*experiencing periods of extreme stress and low mood'*. The referral states that the family suffered 'racial attacks' at their previous home and fires in the temporary accommodation. The

Date	Summary of key event
	children's health was said to be good and details of mother's relevant medical history were included. Screening questionnaires were sent by the Healthy Minds service to the mother and copied to the GP with a view to a telephone interview appointment being held on 8.11.2010. Mother provided the following information: • She stated that she was feeling low living in the hostel and had had a panic attack • She had had panic attacks since aged 11 and had accessed counselling at school • The 'mood assessment' was that the mother had low energy and concentration. She wanted to get out more as there were 4 people living in one room • She reported getting up a lot at night • She reported having a heart murmur, stated that she was on antidepressants for one month but that they did not work for post natal depression • Identified racial attacks in (redacted) involving guns and police advising to move out of area. • Partner was noted to be unemployed • Mother identified 'children at risk to people outside in flats' The account of events in (redacted) given in this consultation exceeds anything in agency records – but may of course be accurate. The mother's stated aim for contact with the services was 'to not feel depressed and low'. The member of staff involved discussed the management of panic attacks and an appointment was arranged for 15.11.2010 The mother did not keep subsequent appointments. She was sent relevant literature about panic attacks. Her non attendance was notified to her GP. She was discharged from the service and letters were sent to the mother and to her GP on 16.12.2010.
12.11.2010	HV1 sought contact with the parents and was told that the family would be moving the following week. She provided details to the relevant health visiting team
10.12.2010	The family signed for new starter tenancy. The follow up visit by the social landlord on 13.1.2011 did not identify problems. On 10.12.2010 the mother phoned HV1 asking for help to obtain kitchen equipment
23.12.2010	Family notified HV1 of their move and intention to register at GP surgery 2.
11.1.2011	Parents and children registered at GP Surgery 2
18.2.2011	Mother, father, Child E and Child D were seen at GP Surgery 2 for new patient registration. Records noted harassment at the previous address. The registration noted the need for the surgery to follow up the overdue immunisations. The family were flagged as 'vulnerable' in the GP surgery i.e. the receptionist dealing with the registration records noted that there were young children who were behind with their immunisations and

Date	Summary of key event
	that the family had moved several times. The receptionist therefore sent a note highlighting the family to the GP who was the practice lead for child protection. This meant that subsequently the family could be discussed at a two-monthly review of vulnerable families at the surgery, though there are no notes of any such discussion until September 2011.

Key events and dates from January 2011 – when antenatal care began – and the birth of Baby C

Date	Summary of key event
21.2.2011	Health visiting records state that the community midwife called the staff nurse in the health visiting service to notify the team of the mother's pregnancy. Expected date of delivery was noted to be (redacted). It is not clear how the midwife became aware of pregnancy as this is before the first date of notification in the midwifery records. This suggests that some contacts with the mother not recorded. The following day the staff nurse contacted the previous health visiting team. The allocated worker was on leave but the staff nurse was given information from the records, including that the family were considered to be 'vulnerable' by the health visiting service i.e. in need of services additional to the 'core' health visiting service.
24.2.2011	Family support worker from a second Children's Centre (in the locality of their new home) was introduced to the mother at a library reading session. Mother gave history of being relocated to the area from (redacted) due to racial harassment.
28.2.2011	The mother contacted (redacted) Children's Centre seeking a cot for her son because he was sleeping in a travel cot. It appears that a cot was supplied during the course of a home visit on 8.3.2011 (though it was not the usual policy of the centre to do this). However it was never used as the family could not put it together and it was collected from the flat at some point in March 2011.
28.2.2011	Antenatal services management review states that the GP surgery informed the midwife of the pregnancy on this date, however GP records suggest earlier information sharing
1.3.2011	Antenatal care booking appointment with community midwife at GP surgery 2. Due to the relatively late booking (redacted) the appointment was offered at the first opportunity, rather than the normal practice of a home visit. The information recorded about the mother's history indicated the need for consultant led care and antenatal appointments at the hospital. This was due to the mother's reported cardiac problem. The midwife also noted that there had been no history of alcohol or drug misuse. The referral to Healthy Minds was noted, though the mother stated that there was no personal or family history of mental illness. Based on the notes the actual reasons for the referral were

Date	Summary of key event
	not explored with the mother in any detail. Records of previous pregnancies were recorded as follows: • Previous births noted in (redacted) and (redacted) Miscarriages noted to have occurred in 2006 and 2010. The parents explained that both moves (from (redacted) and also from homeless hostel) were due to racial harassment. The midwife found this unusual and recalls (though it was not recorded) that she contacted Buckinghamshire social care to find out if the family were known. The midwife states that she was advised that the family had received some help when moving to their current accommodation. However there is no record of this dialogue or this service in social care records. At this booking appointment the midwife did not ask the standard question about domestic violence as the father was present. This standard question was not asked on two subsequent occasions when there were antenatal appointments
1.3.2011	Bucks HV2 phoned the parents and arranged to make a visit, which occurred on 4.3.2011
4.3.2011	HV4 undertook a family health needs assessment because this was her first contact with the mother and children. Mother reported being (redacted) weeks pregnant and that this had not been a planned pregnancy. She said that their circumstances had much improved since moving to self contained accommodation. The (redacted) month health assessment reported that Child E was achieving normal developmental milestones. At this point HV4 decided that the family were no longer in need of a targeted service based on the parental reports of improved circumstances and the positive health assessment of Child E. As a result no antenatal health visiting appointment was made and the next health visiting contact came after the birth of Baby C.
8.3.2011	A Barnardo's family support worker made a home visit to deliver a cot to the family. The worker met the family and was shown the accommodation. She encouraged the family to attend services at the children's centre. No assessment was undertaken as this was not the brief of the visit
21.3.2011	Child D (redacted) began to attend at early education for a morning session, including lunch. He attended for 12 hours per week (4 sessions) until October 2011 when a fifth three hour session became available. No concerns were ever expressed or recorded about the children or family at this nursery. There were a small number of periods of absence, which were notified and explained by the parents (including normal childhood illnesses). These are noted in the chronology to follow. The nursery noted mother's concerns about Child D having a problem potty training at home and advised her about this. They never considered this to be a significant issue (i.e. it was within normal developmental bounds and the mother was just slightly

Date	Summary of key event
	anxious about it).
25.3.2011	Home visit by social housing provider at three month point in tenancy. The mother told the housing worker that she thought that she might be having twins (though there is no other mention of this possibility in any other agency record). The visit was satisfactory. The children were seen and there were no concerns noted.
6.4.2011	Mother attended a (redacted) week ultrasound scan at hospital – normal findings
14.4.2011	Mother attended a (redacted) week antenatal appointment at hospital. Noted that mother had cardiac problem (electrical impulse problem with the heart and not a significant structural problem) which had been diagnosed age 10. She said that she had been under the care of a consultant in (redacted) and had last experienced problems in 2005. The mother's medical records in (redacted) suggest that she had been referred over this period but that in the main she had not attended appointments offered and that there was no current active treatment plan for her cardiac condition when the family left (redacted). On 27.4.2011 the obstetrician wrote to the identified consultant at (redacted) seeking any information relevant to the pregnancy. There is no record of any reply to this letter in the period under review. Next antenatal appointment (redacted) weeks.
28.4.2011	Child D was noted to be absent from nursery until 6.5.2011. Attendance resumed until 3.6.2011 when there was a three day absence which corresponds to contact with the GP over a minor childhood illness
8.6.2011	Paradigm Housing made a 6 month tenancy check. There were complaints of minor incidents of anti-social behaviour made by a neighbour following a noisy barbeque that the parents had had with friends. The neighbour said that he had heard rumours of drug misuse, though this was strongly denied by the parents. Subsequently there were no further references to anti-social behaviour. The neighbour also complained that the family dog and the children were noisy.
9.6.2011	Mother missed an antenatal appointment and Child D was absent from nursery. The mother later explained that this was a two week absence due to chicken pox.
16.6.2011	Child E had two appointments (second on 20.6.2011) for minor childhood illness
27.6.2011	Child D returned to nursery
30.6.2011	The mother did not attend her hospital antenatal appointment. The matron for women's community service was informed as this was the third missed appointment. The antenatal clinic midwife attempted to make contact with the mother by telephone but the mother hung up when she received the call.

Date	Summary of key event
	This was not seen as unusual and the antenatal clinic informed the community midwife and GP. The midwife offered a community appointment on 5.7.2011
5.7.2011	Mother attended antenatal appointment, explaining that the missed appointments were due to chicken pox. Further hospital appointment made for 14.7.2011
14.7.2011	Family did not take Child D to immunisation appointment. This was the scheduled date of mother's antenatal appointment. There is no record of mother attending this; however she is likely to have attended some further antenatal care because the mother was admitted for planned induction of labour on (redacted). There was no intervening appointment recorded.
(redacted)	Mother admitted for planned induction of birth. Normal birth of healthy (redacted) child on (redacted). Cord cut by father; baby was given to mother for skin to skin contact. Birth weight 4320gms (between 91st and 98th centiles).

Key events and dates from the birth of Baby C (redacted) until his admission to hospital in October 2011

Date	Summary of key event
(redacted)	Mother and Baby C were discharged home. Baby C was recorded as being bottle fed. The plan was for there to be a community midwife home visit on (redacted) and then follow up by appointment at the birth centre on (redacted). This was consistent with normal practice for experienced parents. During the planned induction the mother was given an ECG because of her cardiac condition / history. On discharge this information was passed to the GP and the mother was given the advice that she should seek a GP appointment and a referral. The mother saw her GP on 5.9.2011 Subsequently the mother described the findings of this in exaggerated terms i.e. that she was concerned that she might need surgery.
(redacted)	The community midwife made a normal postnatal follow up home visit. No concerns identified, Baby C was noted to be feeding regularly, follow up planned for (redacted). During the following two days repairs were undertaken on the family home by housing staff. They noticed nothing unusual or adverse
(redacted)	Baby C was not taken to the birth centre (High Wycombe Hospital) for postnatal check up.
(redacted)	Post natal home visit by community midwife. Nothing significant in relation to Baby C. Family explained that they missed the appointment on (redacted) because they had no transport. It is known that the family had no car.

(redacted)	Post natal appointment at child health clinic, held at Children's Centre. Baby C said to be feeding well. Weight now 4180g. This weight was recorded in the midwifery records but was not recorded in the weight table in the Personal Child Health Record (PCHR). The reasons for this cannot be established. Baby C was recorded to be taking 90ml of milk every three hours. The weight recorded shows a post birth weight loss of 140g (or 3%) which is well within normal range. Loss of 10% gives rise to concern.
31.8.2011	Barnardo's family worker and play leader (children's centre) had brief opportunistic contact with the family while in the street. The family briefly attended a play session at a local park and were given an updated timetable of activities. Subsequently there was no significant contact with the centre. Attendance at first aid courses was offered but neither parent attended.
(redacted)	HV2 called mother three times to try to arrange a new birth visit appointment without success. HV2 briefly liaised with the community midwife who advised that there were no concerns and reiterated advice given about the infant's stools. Baby C was discharged from post natal care after a further appointment on (redacted)
(redacted)	Health Visitor 6 made the new birth home visit to Baby C - now age (redacted) days. Baby C was asleep during the visit and so was not examined. This is reported to be consistent with expectations, given the circumstances, the fact that the mother was experienced and that there were no reported concerns. The mother had no concerns and reported that Baby C was taking formula milk and feeding well. The health visitor gave the parents information about standard aspects of child health promotion and wellbeing including immunisations, sudden infant death and entitlements to welfare benefits. As father smoked and so the danger of smoking near children was discussed. There is also a record of a normal response to the routine newborn hearing screening dated (redacted). On this occasion the mother disclosed the possible need for surgery due to a heart valve problem. Neither her condition nor the specific medical records indicate that this had been suggested as being necessary. The parents expressed a wish to move house again due to neighbours banging on their wall in response to the children's noise. The parents reported that they had already contacted the housing department for a mutual home exchange. The parents expressed an interest in completing a first aid course at the Children's Centre beginning on (redacted) and a possible nursery place for Child E under a pilot project. Child D was seen playing in the garden by HV who also noticed that Child E's speech was not clear. She noted that the parents were not concerned about this. The parents said that Child D has experienced some problems toileting. He often missed her potty at home but was clean at nursery. The nursery key worker had offered

	toilet training support. There was a discrepancy in the parents' information and the child health computerised records about whether Child D had received his pre-school booster immunisations. Immunisations would be followed up with the GP surgery to offer appointments. The health visitor did this with the practice nurse on 6.9.2011 and the immunisations were completed in October 2011. The health visitor agreed with mother to arrange for the team Community Nursery Nurse to see the family at home in a week to weigh Baby C (because he had not been weighed on this visit) The health visitor decided to review Child E's speech in keeping with the Bristol Speech and Language Screening Tool guidelines. The health visitor recorded her intention to discuss further follow up with HV 1 (who knew the family).
5.9.2011	The mother attended the GP surgery and sought an urgent follow up appointment in relation to her heart problem. The GP's review of past notes confirmed that previous compliance with specialist appointments had been poor. It is not clear if this review happened during the appointment or subsequently. There is no record that this was discussed with the mother to establish the reasons
7.9.2011	Mother phoned Paradigm Housing about the neighbour banging on the wall because he said that the children make too much noise early in the morning
9.9.2011	Having reviewed her records the GP phoned the mother to agree a plan in relation to her heart condition.
13.9.2011	Child D taken to GP because of toileting problems, said by the mother to be stress related, linked to the neighbour banging on the wall. The GP referred her to the community paediatrician by letter.
13.9.2011	Health visiting records from (redacted) for Child D were received on this date
14.9.2011	Baby C was seen at home by appointment by the community nursery nurse. His weight was 4380g (i.e. gain of 200g over previous 14 days). Plotted now on 91st centile whereas he had been around 98th centile at birth. Toileting problems were discussed and the family made reference to the paediatric referral. Advice was given to support the strategy adopted at nursery where Child D used the toilet successfully. The nurse completed a two year pilot nursery programme application for Child E. Community nurse discussed her findings and actions with the health visitor (HV4) after the visit. It was decided that the health visitor would visit herself in seven days because of the relative slow growth of Baby C.
14.9.2011	Paradigm Housing made a visit to undertake the 9 month tenancy check. There had been no further reports of anti-social behaviour by the family. However the neighbour was still reported to be banging on the wall. Housing officer reported attempts to discuss and

	mediate. Family now seeking a three bedroom house as they have third child. No adverse observations were made about the flat or family. It has been noted that during all three housing visits the mother stated that her own mother worked for the housing association, though this is not true. On 16.9.2011 the GP wrote to the housing provider indicating that stress was having an adverse effect on the family and Child D in particular
21.9.2011	HV4 visited and weighed Baby C. His weight was 4500g, a weight gain of 120g in one week. At age (redacted) days this placed him on the 75th centile. However he was reported to be feeding well by the mother. The health visitor arranged to visit again and re-weigh Baby C on 3.10.2011. At this point the health visitor was aware of the slow gain in weight but she was not very concerned about it because her view was that Baby C was thriving and healthy and his mother had reported that he was feeding well. At this point there was a considerable focus on the mother's health. Mother stated that she had fainted at the weekend but that she had not yet received a cardiology appointment. The health visitor agreed to follow this up with the GP. This coincided with the information that the health visitor had about the antenatal period. She knew that there had been concern about the mother's cardiac condition had been paid considerable attention during the pregnancy. The health visitor was not aware of the mother's missed antenatal appointments. The health visiting records state that the mother was advised to discuss her fainting with the GP and that the HV would also do this. She did so at the practice meeting on 26.9.2011. The meeting noted that the health visitor would ask the mother to make a further GP appointment for review. HV2 phoned the mother after the meeting to encourage her to see her GP again.
26.9.2011	The GP referred Child D to child psychiatrist. The community paediatrician (who had received an earlier referral) had stated that it was not an appropriate referral to his service as he had no play therapist to assist in work on toilet training. The child psychiatrist declined the referral on 10.10.2011 suggesting that the health visitor was the appropriate professional to address the issue and that the neighbours might benefit from some mediation.
26.9.2011	Both GP records and health visitor records confirm that the mother's health was discussed at a practice meeting involving the GP and the health visitor (HV4). The health visitor was concerned that the mother had said that she had recently 'passed out'. It was also noted that contrary to the mother's report to the health visitor there was no record of an appointment at the local cardiology unit. The GP said that he would not refer the mother to a cardiologist at this point as 1) there was no treatment plan from the heart specialist in the previous health trust and 2) the mother had not kept previous cardiology hospital appointments. The GP did however ask the

	health visitor to encourage the mother to make a further appointment in order to enable him to evaluate and monitor the mother's condition. The GP asked the health visitor to encourage the mother to make a further appointment with the GP to review her health. There are no written notes of the practice meeting. The concerns about Baby C's slow weight gain were not discussed at this meeting.
3.10.2011	HV4 made a planned home visit. Baby C's weight was 4680g, a gain of 180g in 11 days. HV2 arranged to see Baby C again to monitor his weight in 2 weeks time. She also advised the parents to take Baby C for his 6 week developmental GP check which was due at this point (Baby C was aged (redacted) days). On this occasion the HV watched Baby C being fed and discussed with the father how much milk he was being given. He said that he followed the instructions on the packet for mixing the formula. He had not considered giving Baby C more milk. The health visitor advised the parents to increase the amount of milk given and to ensure that there was always some milk left at the end of the feed so as to ensure that Baby C was getting what he wanted, rather than a fixed amount. The health visitor also agreed to continue to monitor Child D's toileting at a further appointment
10.10.2011	At approximately this date Baby C received a number of injuries which are consistent with physical abuse including fractures to his ribs and to his tibia (lower leg). This is an approximate date based on the estimate provided in the post mortem findings. No professional was aware of these injuries until after Baby C's death and no professional had an opportunity to examine Baby C after this date. It is potentially significant that after this date the parents did not keep appointments with professionals and refused to take calls from the health visitor who was the main professional involved at that point and she was seeking to visit the family about Baby C's weight
17.10.2011	The health visitor (HV4) attempted a home visit planned to follow up Baby C's slow weight gain and Child D's toilet problems. There was no reply and the HV left a note asking the mother to get in contact.
18.10.2011	The following day the HV phoned the family and spoke to the father, who informed her that the mother was out and would be back in an hour. The HV made two further phone calls. Her perception was that both times the phone was answered and whoever answered hung up when the HV said who she was. The HV phoned the surgery and established that Baby C had not been taken for her (redacted) week check and mother had not had her post natal check. She phoned the mother again and again the phone was hung up. She sent her a text message reminding her to contact the surgery to make the appointments again. A copy of this is in the records. This was the last action taken by the health visitor before Baby C was admitted to hospital.
20.10.2011	The GP received a letter from CAMHS declining the referral about

	Child D's toileting problem and advising that the HV should make a tier one intervention. The letter suggested that if this did not achieve progress CAMHS would be available for further advice and consultation to the health visitor
21.10.2011	Child D and Child E were brought late for an appointment for immunisations, which were given. The practice nurse who gave the immunisations states that both parents attended this appointment with all three children. Baby C was not examined as the appointment did not concern him and he appeared to be well. There was no discussion about Baby C's (redacted) week check which was overdue at that time. The practice nurse would not have known that HV4 was concerned about Baby C's slow weight gain and expecting to follow this up further with the family
22.10.2011	Baby C was admitted to hospital via ambulance. The report provided by the father was that he had found him to be 'choking and not breathing' after bathing him and putting him to bed and that he had shaken him in an attempt to revive him.
(Redacted)	Baby C died at John Radcliffe Hospital Oxford following extensive medical involvement and consultation with the parents and other family members
27.10.2011	Baby C's weight at the time of the post mortem examination was 5.125 kg and he was described as being 'well nourished'. This weight was consistent with continued growth along the 50th centile. There was no link between his slow weight gain and the cause of his death.
1.1.2012	The (redacted) health visiting records on Child E were received on this date

3 Evaluation of services provided to Baby C and his family

4.1 Outline of the findings of the SCR

4.1.1 Introduction

4.1.2 This chapter of the SCR overview report evaluates the effectiveness of the services provided to Baby C and his family and the actions taken in order to identify any possible risks to Baby C and his siblings and to safeguard the children if that was necessary. It examines the provision made by agencies individually and by the network of professionals who have responsibilities to safeguard children as a whole. The findings of this report draw extensively on the individual management reviews. This summary has also taken full account of the overview of the case made possible through the scrutiny of all of the available information as well as discussions in the SCR panel meetings and discussions with the authors of individual agency reviews. Relevant documents were made available by participating agencies to the SCR author and the panel.

4.1.3 The evaluation contained in sections 4.2 – 4.15 provides the best account that can currently be given of the effectiveness of the services provided to the children, based on the information available from all agencies at this point. For the reasons explained in section 1 it has not yet been possible to take account of the views of family members.

4.1.4 In this SCR the evaluation in the overview report serves two functions. First it evaluates whether the actions and decisions of agencies with child protection responsibilities had any bearing on the death of Baby C. The SCR has sought to establish whether agencies had any evidence to suspect that the children were at risk of suffering serious harm and whether the death could have been prevented if agencies had taken different decisions or acted differently. Second the SCR provides a wider evaluation of the services provided to the children and their family during key episodes in the case history. The objective is to identify whether there are any lessons that can be learnt so as to improve safeguarding services, independently of any possible link to the death of Baby C.

Judgements about the actions and decisions made by professionals

4.1.5 The Working Together guidance requires that the SCR should bring hindsight to bear in evaluating the actions of professionals and public bodies.[4] Self evidently there is value in seeking to look back objectively at a case history, knowing the outcome and with a fuller knowledge of the events and the actions taken by all of the professionals who were involved. As well as the insight that comes from hindsight the SCR is aware of the danger of what is termed 'hindsight bias'.[5]

4.1.6 So far as is possible the SCR has therefore sought to avoid hindsight bias. In some circumstances it is easy to criticise the decisions and actions of professionals because it can now be seen that they were part of a chain of events that had a tragic outcome. It is much more useful to seek to understand and explain why actions were taken and decisions were made and to consider the influences over professionals arising from the context within which they were working. Only if hindsight bias is set aside is it possible to learn lessons that are relevant to other professionals who find themselves working in similar circumstances.

4.1.7 When evaluating the actions of individual practitioners and managers and groups of professionals and agencies the SCR has taken the following approach:

- judgements about actions and decisions take into account the information that was available to those who took them
- at points it is necessary to evaluate actions and decisions in relation to information that was known to the network of child protection professionals as a whole and would have been available if relevant information had been sought and provided.
- the review has sought to judge the actions of professionals and agencies against established standards of good practice as they were believed to apply at the time when the events in question took place
- if it is relevant the evaluation will distinguish and outline the influence of individual and wider organisational factors in the decisions and actions taken by individuals

[4] *Working Together to Safeguard Children 2010,* Chapter 8 describes the evaluation in the overview report as being '*the part of the report where reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events.*
[5] David Woods et al, *Behind Human Error,* Ashgate (2010) second edition; Sidney Dekker, *The Field Guide To Understanding Human Error,* Ashgate (2006)

Structure of the evaluation

4.1.8 This chapter of the SCR overview report addresses all of the matters set out in the specific terms of reference of this review and others that all SCRs are required by *Working Together to Safeguard Children* to address. The evaluation in this chapter is presented as follows:

4.2 Background information about the family prior to June 2010
4.3 Sharing of information between agencies when the family moved from (redacted) to Buckinghamshire in 2010
4.4 Assessments undertaken
4.5 Identification of risk factors
4.6 Parenting capacity
4.7 Implementation of plans
4.8 Focus on the children
4.9 The impact of diversity and response of agencies
4.10 Policy context and compliance with procedures
4.11 Standards
4.12 Multi agency working (including information sharing)
4.13 Knowledge and experience of staff / professionals
4.14 Management and supervision
4.15 Capacity, availability of resources and any other organisational issues

Outline of the findings of the SCR

4.1.9 Many of the sections of this evaluation are relatively brief. This is for two reasons. First because, relative to some families, there was little agency involvement with the family of Baby C. Although his parents had experienced some instability and difficulty in their lives, in the main they brought up their children without the need for significant additional services.

4.1.10 The second reason for the brevity of the evaluation is that - with the exception of one episode described in the following paragraph – there is no evidence of any significant concerns identified in relation to the health or development of the children and or the care that their parents provided for them. There were no pointers to any of the children being seriously harmed and there was no reason for professionals to take action to protect them.

Aspects of the case history that raise potential concerns and are evaluated in more detail

4.1.11 The only possible exception to this is that during his short life Baby C gained weight more slowly than would have been expected for a healthy child of his age. The post mortem examination has established that there is no connection between Baby C's slow weight gain and the cause of his death. However this is a potentially important issue because the growth of a child at less than the expected rate is a possible indication of concerns about health and development and so it is important that professionals respond in an appropriate way. The response of professionals to this has been evaluated in detail in section 4.5 which deals with any risk factors identified in relation to the children.

4.1.12 The SCR has also noted that during the last three weeks of his life the parents of Baby C appear deliberately to have not taken phone calls from the family health visitor (HV4). This was a new pattern of behaviour so far as this professional was concerned. The parents did not cut themselves off from professional contact altogether because the day before he was admitted to hospital the parents took all of the children to their GP surgery for Child E and Child D to have outstanding immunisations. Baby C was seen that day, though there was no reason for him to be examined. As it is now known that during this period Baby C had some injuries that were possibly caused by abuse the review will discuss the possible significance of the withdrawal of contact by the family. This episode is also evaluated in section 4.5.

4.2 Background information about the parents and their own families

Terms of reference

To evaluate whether there is any significant information about the parents' own families of origin that might have pointed to potential risk to the children

4.2.1 The SCR has collated all of the available information about the family history of the parents and the involvement of members of the extended family in the lives of the children. Within this there is no indication of any concern or factor that might have presented a risk to the children. The family history shows that the parents of Baby C experienced the sort of difficulties that are common to many families. This is dealt with in detail in section 4.3 below. The information provided by agencies in (redacted) indicates that the extended family were described as supportive, particularly when the mother suffered from depression after the birth of her first child and during the pregnancy with her second.

4.2.2 There are very few references to the extended family or wider family history during the life of Baby C. There is no reference to the extended family having any role or contact at the time of the birth of Baby C. No professional in Buckinghamshire recorded any significant information about the extended family and there was no reason for anyone involved to assess their involvement in more detail.

4.2.3 No significant findings or recommendations arise from this aspect of the evaluation.

4.3 Events in (redacted) before the period under review. The sharing of information between agencies when the family moved from (redacted) to Buckinghamshire in 2010

Terms of reference

To establish what information was shared between agencies when the family moved to Buckinghamshire and to consider whether this had any impact on the services provided

4.3.1 When they lived in (redacted) and elsewhere in (redacted) the family experienced difficulties that are common to many families. The mother is recorded as having suffered domestic abuse from a previous partner. She also suffered from post natal depression. The family did not find it easy to find suitable housing and moved several times. There was evidence of conflict with neighbours which triggered their move out of (redacted). These aspects of the history have been reviewed in turn. None of the information available

gives any indication that there were concerns about how the children were cared for during this period. There is no indication at all that any of these factors presented an indication of risk to the two children who were born in (redacted) (or had any implications for the later care of Baby C).

Allegations of domestic violence

4.3.2 The records of both parents indicate histories of possible domestic violence in previous relationships (dating from 2002 in the case of the father and 2005-6 in relation to the mother). In relation to the father the nature of the alleged events is unclear and there is no firm evidence in the professional records to corroborate the allegations.

4.3.3 The events reported in relation to the mother are not specific but they clearly concern a relationship with a previous partner and date from 2005-2006. They were not reported to the police and no more detailed information can be obtained about them.

4.3.4 These incidents might be of significance and domestic violence may have had a lasting impact on the mother. However the circumstances in relation to both mother and father are unclear, both episodes relate to previous partners and both alleged incidents predate the birth of all of the children in this family by several years. In the information available to the SCR there is no indication at all of violence (or of domestic abuse defined in the broadest terms) in the current parental relationship.

The mother's history of heart problems as reported in (redacted)

4.3.5 The mother had a heart condition which her medical records show was first identified in her primary school years. Health professionals in (redacted) knew about the condition and this led to additional provision being made. For example the mother chose to have her first child at a hospital with additional specialist maternity facilities. Some details of the mother's medical history remain unclear and there are discrepancies between her account of her heart condition and the clinical information available. Although she repeatedly brought her heart condition to the attention of professionals the mother's records show that she missed many appointments at the cardiology department at (redacted) Hospital and that she was not cooperating in plans to monitor her condition. The reasons for this are not certain. The level of understanding that the mother had of her condition and medical history were not established. It is impossible to say whether the mother genuinely believed

that her condition was a serious one or whether the mother wanted to have her condition viewed as being a serious and potentially dramatic one for other reasons – possibly because she would have believed that this supported her case for being prioritised for housing allocation.

4.3.6 This history is interesting and there remain unknowns. However there is no indication that either the mother's heart condition or her response to it had any negative impact on the care of her children (in (redacted) or in Buckinghamshire) or that they gave an indication of any risk to the children.

Late booking for antenatal care

4.3.7 The mother booked late for both of her pregnancies in (redacted) (at 26 and 24 weeks). The parent held antenatal and postnatal records were not available to the SCR. The records that could be located give no indication as to the reasons for the mother's late presentations or whether this was investigated by health professionals at the time. There may be many possible reasons for the mother's late presentation this but as there are no records it is not possible to consider this further. (redacted) LSCB may wish to consider whether the lack of availability of antenatal and postnatal records is a wider concern and if so whether any further action should be taken.

4.3.8 Despite the mother's late presentation in two (redacted) pregnancies and the potential complication posed by her heart condition, no subsequent concerns linked to this were recorded during the pregnancy, birth or early months of either of the children.

Maternal depression

4.3.9 The mother reported suffering from depression after the birth of her first child (Child D) and during the pregnancy with the second. The lack of records previously referred to makes it impossible to know if the nature and severity of the depression was evaluated (or if it was whether the detail was not recorded). Perinatal depression is not an unusual phenomenon and on both occasions the evidence recorded was that the mother was well supported by her partner, her own mother and the extended family and that she felt much better after the birth of her second child. There is no evidence of it leading to any concern about either Child D or Child E who both achieved expected milestones and were taken for developmental checks and most of their scheduled immunisations.

The incidents that led to the family leaving (redacted)

4.3.10 The incidents that led to the family moving to Buckinghamshire were unusual. The account from the (Redacted) Police only deals with incidents when officers were involved. There may have been others that were not reported. There is a discrepancy between the police perception that the incidents were essentially a dispute between neighbours and some intimidating behaviour by friends of the neighbour and the parents' stated perception that the incident amounted to racial harassment. It is possible to see how different perceptions of the incidents might have arisen. The neighbours were black; the parents were white. The parents may have perceived the conflict to be racial in nature, but the police officers recorded no evidence that crimes had been recorded or that there were racial threats or a racial motivation to the incidents. Consequently they did not record the incidents as such.

4.3.11 By creating a record of their contact for the local authority (the (Redacted) notification) it is clear that the police were sensitive to the potential impact on the children of threats to the father from neighbours, regardless of any issue of race. There is no indication that this had any bearing on the welfare of the children, other than causing them to move home.

4.3.12 There are some discrepancies in the recording of information in the records of the Anti-Social Behaviour (ASB) team in (redacted). It is clear that no action was taken over the alleged harassment; however a number of different accounts are given as to why this was. There may be scope for (redacted) to consider this in more detail in order to improve the response of the ASB team. This is a local issue and there is no evidence at all that it has any bearing on the care received by the children or the subsequent death of Baby C.

4.3.13 The parents subsequently repeated their description of being subject to racial harassment to several professionals in Buckinghamshire. All of the professionals involved in Buckinghamshire who were given this account accepted it. One health visitor thought it unusual enough to warrant enquiries to check out with a previous health visitor in (redacted) to see if social care had been involved. A midwife states that it led her to check with the local authority (in Buckinghamshire) to see if the family were known. Neither enquiry was recorded by the professional who now reports making it. There are no social care records of either enquiry although the local authority

reports that it has systems for recording general enquiries in its duty system, even if the name of the family is not given. This is the subject of a recommendation to Buckinghamshire County Council to verify that these systems are in place and working effectively.

4.3.14 The parents repeated their account of racial harassment on many occasions. They may have been genuinely frightened and they may have believed that the incidents were motivated by racial factors. Alternatively they may have exaggerated the extent of the problems that they had experienced. As their account of the incident underpinned their case for housing in Buckinghamshire it is possible to see why they would have wanted the incidents to be seen as serious. Once again it is not possible to understand this fully, but as with other aspects of the family's history, there is no indication that what happened or the family's response to it had any direct bearing on the care of the children or on the risks to Baby C.

4.3.15 Whatever the nature of the incidents all the indications were that the family had sought the help of professionals in an appropriate way. There was no reason for professionals to see the incidents as being directly relevant to the care being provided for the children, except that it meant that the family had moved hurriedly and were living in an area that they did not know well and that they therefore needed to be signposted to relevant services.

An overview of the family's history in (redacted)

4.3.16 The family had some troubling experiences in (redacted). Taking them all into account, the history is 'eventful' but not an indication of any risk of harm to the children. There are some discrepancies and gaps in information and the mother did not take up all of the services that were on offer in relation to her own health. She twice presented very late for antenatal care, which could have led to health concerns for her and the unborn children, but the reasons why this happened cannot be established. There is no evidence that the children's health was harmed as a result of this.

4.3.17 No single professional had an overview of all of these events and discrepancies in information. Given their nature and timing there was no reason why any professional would have been in a position to know about all of them or should have attempted to collate them. Regardless of the gaps in information and the discrepancies in accounts of events none of these events points to any indication of risk to the children and none of the professionals

who had contact with the children believed them to be at risk of any harm. At most the background history of the family in (redacted) point to parents who might benefit from additional support in bringing up their children. This is what they accessed in (redacted) (via a Children's Centre) or were offered (through additional medical appointments). This is the sort of service that they subsequently received in Buckinghamshire.

Sharing of information between (redacted) and Buckinghamshire

4.3.18 The family left (redacted) in a hurried way and this meant that a number of services did not know that they had moved to Buckinghamshire. However even if they had known there was no specific reason for professionals in (redacted) to have referred the family for additional support because the concerns that there had been about the family in (redacted) (domestic abuse, maternal depression and late take up of antenatal care) were either historic or had been resolved by the time the family left (redacted).

4.3.19 Later a Buckinghamshire health visitor sought information and records from her colleague in (redacted). There was a lengthy delay in forwarding health visiting records from the (redacted) RIO system to the health visitor in Buckinghamshire. (redacted) may wish to investigate the reasons for this further because if it is a widespread or unknown problem it could have serious implications. However in this case there was phone contact between the two health visitors to share information so the delay in transferring records did not impact on the care provided to the family.

4.4 Assessments

Terms of reference

To establish what assessments were undertaken by agencies in Buckinghamshire and to consider the quality of those assessments; to establish if assessments took full account of the information available to the agency; 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; to consider the key relevant points / opportunities for assessment and decision making in this case in relation to the child and family. Do assessments and decisions appear to have been reached in an informed and professional way; did actions accord with assessments and decisions made; were appropriate services offered / provided, or relevant enquiries made, in the light of assessments?)

4.4.1 This section of the report deals with the main period under review following the family's move to Buckinghamshire in mid 2010. The extent of the

assessment undertaken by professionals was limited because in a number of settings the children did not appear to have any additional needs and universal services were available to children and families without the need for any additional assessment

4.4.2 Once engaged within universal services professionals may undertake further assessment as part of the normal course of service delivery or if they perceive there to be a need. Agencies have arrangements to carry out assessments but in this case it was not considered necessary because no indicators of additional risk or need were identified

4.4.3 In fact the parents' contact with services and the care that they were observed to offer the children was perceived very positively. For example Child D attended regularly at a nursery for a half day provision including lunch. He was perceived to be a healthy child, developing normally. His parents were noted to look after him well and to socialise in a friendly way with the parents of other children.

4.4.4 The children and family had a limited number of contacts with the local children's centre. Services were offered but not taken up, which is not unusual or necessarily concerning. No concerns were identified in the brief and limited contacts that took place.

4.4.5 The only formal assessments of need were made by the midwife at the booking in appointment during the pregnancy with Baby C's mother and the two assessments undertaken by the health visitor when the family moved to their permanent accommodation and at the time of the new birth visit to Baby C.

4.4.6 At the transfer in health visiting assessment in August 2010 the two children (Child D and Child E) and the family were perceived as being vulnerable and in need of additional support because of the circumstances in which they had left their home in (redacted) and the accounts given of how stressful it was living in temporary accommodation. In health visiting contact prior to the birth of Baby C minor concerns were noted about the children's development (for example Child E was noted to have some difficulty sitting up at age 9 months). The health visitor gave appropriate advice and the parents appear to have followed it because the problems were resolved.

4.4.7 After the family moved to permanent accommodation in March 2011 a health visitor (HV4) from the locality undertook a second 'transfer in' visit. At this

point the family's circumstances were assessed as being much more positive as they now had permanent accommodation. Minor concerns about the children's health and development were believed to have resolved and as a result the family were viewed as being no longer vulnerable and therefore only in need of the core health visiting service. This assessment adopted the approach expected and there is no evidence that any information about risk factors or concerns was missed. The re-designation of the children as only requiring a core or universal service (leaving it to the parents to initiate contact if they wanted) was understandable and justifiable.

4.4.8 After the birth of Baby C a further health visiting assessment (based on the new birth home visit) took place. Baby C could not be weighed or examined at this assessment visit because he was asleep and so arrangements were made for this to be carried out at a second home visit a week later. The records show that all other relevant aspects of Baby C's health and circumstances were assessed and standard advice was given on matters such as SUDI and smoking. It is positive that health visitor took the opportunity to update her assessment of the older children. In relation to both children specific health and developmental needs were identified (Child E's speech and Child D's toileting difficulties).

4.4.9 These health assessments were in keeping with what should be expected. No significant concerns or risks were identified. The steps taken to respond to the needs identified were in keeping with what would be expected. Section 4.5 deals in more detail with the question of Baby C's slow growth which subsequently emerged as a problem.

4.4.10 When the family registered at GP surgery 2 the children were identified as being 'vulnerable'. This meant that details of the family were passed by the receptionist to the GP who took the lead on safeguarding and that depending on any subsequent events the needs of the children might be considered at the practices bi-monthly multi-disciplinary practice meetings. The reasons for defining the family as vulnerable were given as being that there were young children who were behind with immunisations and that because of conflict with neighbours they had moved more than once in a relatively short period of time.

4.4.11 This is a very low threshold for identifying a family as vulnerable and in many GP surgeries such criteria would encompass a large percentage of registered

children. It has been recognised that the social context is important. This surgery serves a very affluent area and it has a relatively small number of families who might be classified as vulnerable. However within the particular context this was appropriate.

4.4.12 Further consideration has been given to the actual measures that followed from this and the way in which the GP practice multi-disciplinary meetings functioned. At the time no records of discussions at these meetings were maintained and when it was judged to be necessary notes were made on individual patient records. However it has been established that the first time that Baby C and his family were discussed was in late September 2011 when the health visitor (HV4) mentioned her concerns about the mother's heart condition and agreement was reached with the mother's GP about how to approach her. The meeting had not discussed the family or children when during the pregnancy the mother had missed a number of antenatal appointments and had required additional care because of her heart condition.

4.4.13 The arrangements for identifying families as vulnerable in this surgery and holding meetings to discuss them have been considered in the health overview report, which offers advice and makes a recommendation in relation to this. It is considered that this is a useful initiative and in many aspects an example of good practice which could usefully be developed further within the surgery and might prove to be a useful model for other surgeries.

4.4.14 Section 4.5 deals with the specific question of the assessment of the slow weight gain of Baby C.

4.5 Identification of any risk factors and the response of agencies

Terms of reference

To establish what risk factors were identified in relation to the children

4.5.1 This section of the report reviews the information that was available in relation to seven different possible identified concerns or risk factors that appear from records and interviews with staff to have been present in the family history during the period when the family lived in Buckinghamshire. Evaluation of these leads to the conclusion that although some concerns were identified these were resolved or were minor. Taking the history as a whole there were no risk factors pointing to a significant risk to the health or safety of Baby C

and there was no indication whatsoever that he might suffer the severe injuries that are believed to have caused his death.

Maternal mental health

4.5.2 Section 4.2 above deals with the mother's experience of antenatal and postnatal depression reported when she lived in (redacted). This had been resolved by the time the family moved to Buckinghamshire and there was no reason for professionals to share information about it when the family moved.

4.5.3 The records and interviews with staff indicate that there was no recurrence of depression during the mother's pregnancy with Baby C or during Baby C's life.

4.5.4 In October 2010 the mother reported that she was suffering from panic attacks when she attended her first appointment at GP Surgery 1. She reported that she had suffered such attacks intermittently since childhood and reported that recent stressful events and the difficult living conditions in the hostel had caused them to return. The GP made a swift and very appropriate referral for mental health screening and preliminary assessment and this took place over the phone within two weeks of the referral. After the telephone interview written information was provided and further appointments were offered, though they were not taken up. The outcome of the contact was reported back to the GP. He did not subsequently discuss it with the mother as he had no further contact with her before she moved house and changed GP.

4.5.5 The impression created by subsequent records is that the problem was resolved to a considerable degree by the family moving to permanent accommodation and the mother reported no further panic attacks or other mental health difficulties to any professional that she was in contact with. There is no indication that the panic attacks ever had a negative impact on the mother's parenting or that they posed a risk to the children.

4.5.6 The mother spoke to both her health visitor and GP about the panic attacks. It is noted that there was no communication between the two professionals and that the GP made the referral to 'Healthy Minds' without informing the health visitor. This was a missed opportunity to share information that might have been useful to both professionals. The health management reviews and the health overview report make recommendations in relation to information sharing and working arrangements between health visitors and GPs.

Domestic violence

4.5.7 Section 4.2 deals with the allegations of domestic violence involving previous partners of the parents when they lived in (redacted) and before they had children. There is no evidence of any concern in relation to domestic violence or abuse during the period when the family lived in Buckinghamshire.

4.5.8 It has been recognised that the midwife who booked the mother at her first antenatal appointment did not ask the standard screening question about domestic violence because the father was present. This was a sensible approach. However there is no indication that this information was sought at subsequent antenatal appointments. The management review of antenatal care notes that the current format for recording antenatal care information is parent held (which might make it difficult to record information in some circumstances) and does not in any event easily lend itself to recording the outcome of an enquiry about domestic violence if it is positive. The management review makes a recommendation on this and the LSCB will take forward a national recommendation to seek to standardise the recording of information arising from enquires made during pregnancy.

Homelessness and lack of resources

4.5.9 The family's homelessness and their need to flee threats in (Redacted) were the first presenting problem for agencies in Buckinghamshire. The family continued to experience a degree of conflict with neighbours. There were minor allegations of anti-social behaviour after they had been rehoused, some made by the family and some made by neighbours. None had any major implications for the children.

4.5.10 The response of agencies to the family's homelessness and to minor reports of anti-social behaviour was appropriate, seeking to meet the needs of the family and children and to ensure that the family was making good use of the tenancy offered. No concerns about the children were identified during the periodic contact that various housing staff had with the family. Agencies followed up all adverse reports carefully, challenged the parents over minor (though unsubstantiated) allegations of anti-social behaviour. Housing staff showed themselves to be alert to the potential needs of the children.

4.5.11 Both parents were without work during the time that they lived in Buckinghamshire. There is no indication of the involvement of any services with the family in relation to this. The records indicate that both parents saw

themselves as being actively involved in the care of their children and that they were not actively seeking employment. This limited their access to resources, impacting on the care of the children indirectly e.g. through lack of access to transport and services. However it did not significantly contribute to any risk to the children.

Late presentation of pregnancy

4.5.12 The mother presented at approximately (redacted) weeks into her pregnancy. Technically this leads to her being defined as a late booker, though in comparison to her first two pregnancies (presenting both times at over 24 weeks) this was a substantial improvement. During her pregnancy the mother missed a number of antenatal appointments. The reasons for this are not fully explained though it is reported that at least one appointment was missed when the eldest child in the family was unwell. As the antenatal care was consultant led the majority of appointments offered were at the hospital and it would have been more difficult for the family to attend these as they had no car. In contrast GP appointments and home visits were kept.

4.5.13 There is at least one gap in the parent held record when the mother must have attended an appointment which was not recorded.

4.5.14 Whilst missing antenatal appointments is not desirable there is no indication that this had any negative impact on the birth or subsequent care of Baby C.

The health and development of the other children in the family

4.5.15 During the mother's pregnancy with Baby C and during his life the older children in the family experienced a number of minor health and developmental problems. These included concerns about Child E not sitting up very well at age 8 months, concern about his speech at the new birth visit to Baby C and concern about Child D's difficulty toileting. None of these would be considered to be a serious or unusually concerning difficulty and their main significance from the perspective of the SCR is that the parents sought professional help and advice in relation to these and there is no indication at all that they neglected their children's needs or responded in a way which would have given professionals cause for concern or suspicion.

Baby C's slow gain in weight

4.5.16 Baby C gained weight slowly from birth. This is a potential cause of concern because in some babies slow weight gain may be an indicator of a serious health problem or a symptom of poor parenting. In fact Baby C was described by the pathologist as being 'well nourished' and the post mortem findings established that there was no link between Baby C's slow weight gain and the cause of Baby C's death.

4.5.17 Notwithstanding this it is important to understand and evaluate the actions of professionals in responding to this presentation. Although there is no indication that different actions would have changed the outcome for Baby C the evaluation of this episode by the SCR panel and the overview author has established a number of points for potential learning and service improvement.

4.5.18 The weight of Baby C based on the Personal Child Health Record (PCHR) was as follows.

Date	Age	Weight	Centile position	Comment
(redacted)	Birth	4320g	91st - 98th	
(redacted)	10 days	4180g		Hospital record not in PCHR. Loss of weight after birth is normal. This 3% loss was within normal limits
(redacted)	23 days	4380g	91st centile	Baby was not weighed on new birth visit 5/9/2011 because he was asleep
(redacted)	32 days	4500g	Just above the 75th centile	Health visitor aware of slow weight gain but judged Baby C to be healthy and thriving
(redacted)	41 days	4680g	Between the 75th and 50th centile, closer to the 50th	Health visitor arranged to see Baby C again to monitor his weight in 2 weeks. She also advised the parents to take Baby C for his 6 week developmental GP check
27/10/2011	postmortem	5125g	Continued steady growth on 50th centile	

4.5.19 The PCHR also contains a centile growth chart, which enables health professionals to plot a child's growth against the typical weights and heights of the UK child population. An example is given in Appendix 3. Plotting the weight and height is designed to enable easy visual recognition of the child's growth in comparison to the expected trajectory and in comparison to the rest of the population. The chart is marked with centile lines showing typical growth distributions and projections – for example a child whose weight falls on the 50th centile typically falls at the median (in the middle) of the distribution of 100 children of the same age.

4.5.20 As children grow height and weight tend to follow a steady trajectory, keeping not necessarily to a specific line, but sitting reasonably consistently within the space between two centile lines. The guidance attached to the current 0-12 month growth chart underlines the potential significance of a child's weight deviating significantly from the normal population trajectory:
'Babies do not all grow at the same rate, so a baby's weight often does not follow a particular centile line, especially in the first year. Weight is most likely to track within one centile space (the gap between two centile lines, see diagram). In infancy, acute illness can lead to sudden weight loss and a weight centile fall but on recovery the child's weight usually returns to its normal centile within 2–3 weeks. However, a sustained drop through two or more weight centile spaces is unusual (fewer than 2% of infants. The guidance states that such children *should be carefully assessed by the primary care team, including measuring length/height'.* [6]

4.5.21 It is clear that the health visitor identified Baby C's slow weight gain as a potential concern. She paid close attention to his weight, appearance and overall health on all of her visits. She had a good understanding of the potential significance of slow weight gain and she had received training in relation to the topic and the use of centile growth charts in the twelve months prior to her contact. The course trainer had been on a specialist World Health Organisation programme on the topic.

4.5.22 Notwithstanding their obvious advantages and the training provided, the use of centile growth charts for very small children remains challenging in ways that the presentation of the basic facts in the key events in section 3 of this report and the preceding paragraphs does not easily convey.

[6] World Health Organisation, Department of Health, Royal College of Paediatrics and Child Health, Girls UK growth Chart 0-4 years,(2009)

4.5.23 Some of the complexities illustrated in this case will apply generally to the use of centile charts and so merit further investigation and review:

- Not all weights accord exactly with a marked grid line so there is always a degree of discretion and judgement required when marking the chart. Close examination of the original record in this case shows that the entire data set consists of five pencil marks, mapped by three different professionals in an area which measures 2.5cm x 1.0 cm. This is illustrated in Appendix 3.
- There seems to be a degree of uncertainty as to whether it is crossing bands or crossing centile lines which is important
- When interviewed the health visitor indicated some uncertainty as to whether Baby C's fall in weight constituted a drop through two or three centile bands
- The significance given to the birth weight as opposed to the lower base weight measured after birth is important i.e. did the measurement of Baby C's weight begin at the 98th centile (in which case by 21 September his centile weight trajectory had declined through more than two centile bands) or at the 91st, making the decline appear to be less dramatic.
- It is much easier to identify trends in growth over several months than it is to make judgements about the trajectory of growth in a young infant based on a small period of time where weights are recorded closely together
- It is not clear from the current guidance whether or not it was correct of the health visitor to give so much credence to her own judgement that Baby C appeared to be thriving and healthy, or whether it would have been correct to interpret the guidance in a more rigid and procedural manner.

4.5.24 Discussion has revealed a number of points at which the guidance given to staff and the interpretation of guidance may need to be clarified. It would certainly be more helpful if rather than simply referring to a response from the primary care team the guidance gave more emphasis to early discussion and information sharing in order to establish the wider context and any relevant background social and environmental factors. In this case knowledge of earlier missed appointments might have considerably influenced the interpretation of the data in the PCHR

4.5.25 Both the individual management review of health visiting services and the health overview report have identified that there should be a review of the

guidance and training that are currently provided to health professionals (and particularly health visitors) on the interpretation of growth charts and the response of health professionals to slow weight gain. The findings of the SCR strongly suggest that more emphasis is placed on gathering relevant background and social history and early inter-disciplinary discussion of slow weight gain. Health professionals who use and need to interpret growth charts could usefully be consulted to make sure that training and guidance deals with all of the relevant issues in addition to those highlighted in this case.

Withdrawal of the family from contact with Health Visitor after 3 October 2011

4.5.26 On 17 and 18 October the parents avoided contact with the health visitor (HV4). It now seems likely – based on the post mortem findings - that by this point Baby C had been injured on one or more occasions. The circumstances remain unknown, but it is possible that the parents' avoidance of professional contact may have been because one or both parents had knowledge of incidents involving Baby C. This could not have been known to the health visitor and as far as she was concerned the parents' action in ending phone calls with her was the first indicator of possible non-cooperation. Other than expecting the parents to take Baby C for his (redacted) week check, it is not clear what action the health visitor proposed to take in response to this. As only three days elapsed between the last truncated phone call between the parents and the health visitor and Baby C's admission to hospital it is not possible to know what her next move was going to be.

4.5.27 The withdrawal of family from contact with professionals in the period immediately before a child is seriously harmed (sometimes referred to as 'closure') is a phenomenon that has been noted in the history of a number of child deaths. [7] The literature recognises that it is very difficult for professionals to judge the significance of missed appointments, an apparent withdrawal of contact or any other change in parental behaviour. Often the true significance can only be judged with the benefit of hindsight. Given the information at her disposal the health visitor should not be criticised for acting as she did. She had no reason at all to suspect that Baby C was at risk of serious physical harm.

[7] P Reder, S Duncan and M Gray, *Beyond Blame – Child Abuse Tragedies Revisited,* Routledge (1993)

4.5.28 In other cases this may be very significant and the LSCB should ensure through publicising the findings of this SCR and through its wider monitoring and training functions that agencies make professionals aware of the need to reflect on significant changes in parental behaviour when they are working with children especially where there are grounds to suspect a risk of significant harm.

4.6 Parenting Capacity

Terms of reference

To establish to what extent the parenting capacity of the parents was considered and addressed

4.6.1 The nature of the assessments undertaken by professionals has been set out in section 4.4. These were determined by the limited contact that professionals had with the family and by the fact that there were no grounds for concern that would have given rise to the need for detailed assessment of parenting. This was entirely justified by the circumstances.

4.6.2 In so far as professionals (both in (redacted) and in Buckinghamshire) formed an assessment of parenting capacity it was a positive one, based on the limited evidence available. There was no reason to suspect significant harm or even more general concerns about the children's welfare. It was appreciated that the family had faced a number of practical difficulties but the evidence was that the parents had addressed these in a constructive way and that they were responding positively to the needs of their children. The mother was noted by a number of professionals to be anxious about her circumstances and her children – but there was no indication that her anxiety was impacting negatively on her parenting or on the children's health and welfare. The father was known to be involved and supportive and to take on responsibilities in relation to the children.

4.6.3 With the comprehensive overview of all the professional contacts now available to the SCR it is clear that the mother had a tendency to exaggerate her accounts of her circumstances and the difficulties faced by the family. This included the following:

- Possibly overstating the nature of the harassment that had led to the family leaving their home in (redacted)

- Overstating or misinterpreting the seriousness of her heart condition and the treatment that might be necessary for it (whereas in fact she had repeatedly missed appointments for this at (redacted) Hospital, her condition is one that often requires no active intervention and there had been no suggestion at all of a need for surgery)
- Stating on three occasions that her mother worked for the housing provider (which is now known to be untrue)
- Overstating the extent of her panic attacks and mental health problems (for example there is no evidence that she had been treated with antidepressant medication)
- Overstating the extent of her contact with social care services
- Suggesting that she was going to have twins (whereas there is no health record to indicate that this was ever in prospect)
- Stating that her family had paid for private medical care during her earlier pregnancies (there is no evidence for this)
- Stating that there was a waiting list at the Children's Centre (which was not so)
- Stating that she had experienced a still birth at age 16 (a potentially significant event which would almost certainly show up in medical records but does not).

4.6.4 It remains unclear what interpretation should be placed on these episodes. It is possible that the mother had genuinely misunderstood events. It is also possible that she was knowingly exaggerating her own condition and the family's predicament in order to gain access to services and housing, or that taken together these statements are evidence of some personality trait. Elements of a combination of one or more of these explanations may apply. It is impossible to know what significance – if any – to attach to this. Regardless of the explanation the view of the SCR panel and the overview author is that it would not have been possible for any professional to have linked together this series of disparate events and comments. Even if this had happened it would still not have given any firm indication of potential risk to the children.

4.7 Implementation of plans

Terms of reference

To establish if plans were implemented and to what extent the plans addressed any risk factors identified in the assessments. To establish if there were factors which enhanced or impeded working relationships with the

parents. To establish if staff within agencies co-operated to achieve the best outcomes for the children and where relevant, were appropriate child protection or care plans in place, and were child protection and / or looked after reviewing processes complied with? Did actions accord with assessments and decisions made? Were appropriate services offered / provided, or relevant enquiries made, in the light of assessments)

4.7.1 The plans made in relation to the children and their parents were limited by the nature of the professional contact and assessment that had taken place. This was shaped by the perceived needs of the children and the actions of professionals were entirely consistent with the information available to them and their understanding of the children's needs and circumstances. The identification of risk factors in the assessments undertaken has been addressed in earlier sections of this report (see 4.4 and 4.5 above). In the main plans were implemented. The only significant exception to this was the plan to address Baby C's slow weight gain which was not implemented because the parents withdrew from contact at a crucial point (see section 4.5).

4.7.2 The family largely cooperated in the implementation of plans until the final days before Baby C's death. The reasons for their change in behaviour cannot be determined. They may emerge through the criminal investigation but it is possible that they may never be understood.

4.7.3 Given the circumstances of the case there was never any need for referral for child protection investigation or any child protection plan.

4.7.4 Implementation of services could have been enhanced at several points if there had been a greater level of information sharing between health professionals. This is discussed in detail in section 4.12. There is no evidence that these missed opportunities for information sharing and collaborative working had any impact on the final outcome for Baby C.

4.8 Focus on the children

Terms of reference

To establish to what extent the "voice of the child" was heard in terms of understanding the needs of the child and taking account of their experience in the family. To establish what extent the "voice of the siblings" were heard in terms of understanding the needs of the siblings and taking account of their experience in the family. Was this information recorded? Were practitioners aware of and sensitive to the needs of the children in their work? Were practitioners knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

4.8.1 As the eldest child in the family was under four at the time of Baby C's death it was not possible or appropriate for professionals to seek to establish their wishes and feelings. For children who are not subject to a child protection investigation or looked after by the local authority there is no statutory expectation to do so. The professional responsibility is to seek to understand the needs of all of the children, to observe them with care noting comments made in records, and to make the children's needs the focus of interventions.

4.8.2 Throughout the case history there are numerous indications that this is what professionals did through their close observation and attention to the circumstances and needs of children and their evaluation of the possible impact of the practical problems faced by the parents on them. The evidence is that practitioners were aware of and sensitive to the needs of the children and recorded their assessments properly. For example: police officers spotted the potential impact of stress on the family and notified social care staff in (redacted); all of the professionals in Buckinghamshire recognised the potential impact of the stresses involved in repeated house moves and responded accordingly; the minor developmental and health problems of Child E and Child D were recognised and professionals responded appropriately .

4.8.3 The only point at which a professional became aware of something that might have been a potential indicator of abuse or neglect was when Baby C failed to gain weight in line with normal developmental expectations and it is clear that the health visitor was sensitive to this issue and was taking action to address it in the four week period before Baby C's death. This has been discussed in detail in section 4.5 above.

4.9 Diversity

Terms of reference

To establish if the diversity needs within the family were identified and addressed; was practice sensitive to the racial, cultural, linguistic, religious identity and any issues of disability of the child and family, and were they explored and recorded?

4.9.1 Baby C lived in a white family of UK origin. Her parents were unemployed and so far as can now be established had no family support in the area to which they moved.

4.9.2 Agencies were consistently mindful of the potential impact of social exclusion and deprivation and took steps to make resources available to the family.

Some – such as Barnardo's - went beyond their normal brief. Resources were offered to the family though a number of services which might have been helpful but were not taken up (e.g. attendance at the Children's Centre, face to face support for the mother about her panic attacks). It has not been possible to establish why this was.

4.9.3 The family had a perception that they had been forced out of their home in (redacted) due to racial harassment. It is not clear if this arose from a genuine concern or if it was exaggerated. Nonetheless it is clear that – even if they arrived at a different conclusion – (redacted) Police Service officers did actively consider whether there was a racial motivation to the actions of the neighbour and his friends. Two professionals in Buckinghamshire recollected that they found the mother's account of this as being unusual. Interestingly they did not clarify it with the family – which might have added to their assessment of the family's needs - though they did contact other agencies to seek to clarify whether the family were known. The circumstances in which the family left (redacted) were not considered by any professional to give rise to a safeguarding concern – and there is no indication that they did. The SCR panel viewed this episode in the family history as being unusual and significant – in the sense that it led the family to have to relocate, disrupting the children's lives. However there is no indication that this was relevant in any way to risk of harm to the children, or to the death of Baby C. As the events occurred in (redacted) and concern local services the LSCB there should consider whether there is any additional learning for local services.

4.9.4 The family gave no information about any specific religious affiliation and there is no evidence that religion played any significant role in the case history or the approach that the family adopted to the care of the children.

4.9.5 The management review of maternity services notes that midwives did not record all of the information about ethnicity and religion that they should have, given that there is a clinical need to differentiate the heightened risk of genetic disorders (such as Thalassaemia and Sickle Cell) occurring in different racial and ethnic groups. It is accepted that this was likely to have been an oversight in recording in the specific case rather than an indication of wider inattention to the issue.

4.9.6 No specific findings or recommendations arise from the review in relation to this aspect of service provision.

4.10 Policy context and compliance with procedures

Terms of reference

To establish to what extent individual agency and multi-agency policies were adhered to and to comment on the adequacy of those policies. Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

4.10.1 The use of child protection procedures was never required by the circumstances of the case until the point at which Baby C was admitted to hospital. The actions and decisions of professionals in relation to this fall outside of the terms of reference of the SCR, however all the indications are that the local procedures were implemented in a very satisfactory fashion once the extent and the nature of the injuries to Baby C was recognised and that in particular there was a high level of skilled professional working involving police, social care and hospital staff.

4.10.2 At no point prior to this were there grounds to refer any of the children because of suspected harm and there is no indication that any risk factors were missed or overlooked by professionals. Nothing in the findings of the SCR indicates any need for any significant change in the child protection procedures. Section 4.5 and the health overview report have addressed the issue of Baby C's growth and the guidance to health staff on the use of centile growth charts.

4.11 Standards

Terms of reference

Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

4.11.1 It follows from the findings of the previous section that the work in this case was consistent with individual agency and local multi agency procedures and expected standards. Although there is no evidence that they had any impact on the final outcome for Baby C there were missed opportunities for closer joint working between some health professionals and these are described in detail in the following section of the report.

4.12 Information sharing and collaborative working

Terms of reference

To establish if agencies shared information appropriately and involved other professionals or agencies as necessary. Were there any issues in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services

4.12.1 Arrangements for information sharing between agencies in (redacted) and Buckinghamshire have been described and evaluated in detail in section 4.3 above. (Redacted) LSCB is invited to consider whether further action is required in relation to these findings.

4.12.2 Within Buckinghamshire there are a number of examples of effective practice in sharing information and collaborative working. When the family moved there was good information sharing and service coordination between health visiting teams in different localities. There was some good sharing of information between primary care, antenatal services and health visitors at the beginning of the mother's pregnancy with Baby C.

4.12.3 It is an example of good practice that the GP Surgery 2 holds regular inter-disciplinary meetings about families that are viewed as being vulnerable. However the criteria for inclusion of families within this system are not clear and at the time of the incidents that have been reviewed outcomes of the meetings were not fully recorded. The SCR notes that there have been a number of changes in relation to the organisation and recording of these meetings since the events under review. It is recommended that the arrangements for these meetings should be refined and extended without them becoming overly bureaucratic in a way that would risk losing the flexibility that they offer to respond to the needs of children.

4.12.4 Notwithstanding these positive examples there were a number of instances where there were missed opportunities to share information between health professionals which might have enhanced the service to the children. These were:

- Lack of liaison between the GP and the health visitor about the GP's decision to refer the mother to the 'Healthy Minds' service. The health visitor had also received reports from the mother about her panic attacks and would have been able to work more effectively if she had known that the GP had made this referral (and that the mother had not taken it up).
- There were gaps in the completion of information (including one weight measurement) by midwives in Baby C's PCHR.

- There was only limited information shared by the antenatal service with the community health service and primary care about the mother's pregnancy with Baby C. It would have enhanced the health visitor's new birth assessment This appears to have been influenced by the fact that the antenatal care for Baby C was consultant led and hospital based.
- There was a missed opportunities for discussion between the health visitor and the GP in relation to Baby C's slow weight gain, particularly as he was due to have his (redacted) week check at this time
- Discussion between the GP and the health visitor about Child D's toileting problems would have avoided the need for referrals to specialists because (as the psychiatrist correctly recognised) this was a problem that the health visitor was best placed to address, probably in combination with Child D's nursery
- There was no liaison between the GP practice and the health visitor about the decision to consider the children in the family as vulnerable and to coordinate plans following this decision

4.12.5 As these matters all relate to liaison between health professionals the health overview report has made specific recommendations on in relation to them, building on the detailed findings of the individual management reviews. These recommendations are endorsed by the SCR panel and the independent overview author.

4.12.6 The individual management review of GP and primary care services has asked the overview report author and the panel to consider recommending that the location of health visitors is reviewed so that they are aligned better to GP practices. This is put forward in the belief that this will lead to better liaison between GPs and health visitors and be in the interests of patients. The panel and the SCR overview author have considered this and do not feel that it is appropriate to make such a recommendation for the following reasons:

- The review has highlighted both missed opportunities and good practice in relation to joint working between health visitors and GPs, suggesting that good practice is not dependent on co-location or attachment of staff
- There is insufficient evidence from this SCR to justify a fundamental review

4.13 Knowledge, experience and training of staff / professionals

Terms of reference

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

4.13.1 The SCR panel provided a format for the authors of individual management reviews to collect information in a systematic way about the experience and training of staff involved with Baby C and his family. This information and the individual management reviews confirm that across the agencies the staff dealing with the family in Buckinghamshire were experienced and appropriately qualified and trained to deal with the type and level of concerns that were apparent in this case history. There is no evidence that a lack of training or experience had any negative impact on the case history or the outcome for Baby C.

4.14 Management and Supervision

Terms of reference

To establish if staff directly involved had appropriate supervision and managerial guidance. Were senior managers or other organisations and professionals involved at points in the case where they should have been? Was there sufficient management accountability for decision making?

4.14.1 All of the individual management reviews have explained the normal arrangements for supervision within their services. All agencies have clear expectations about the sort of circumstances in which staff are expected to bring a case to the attention of a manager or discuss a case in supervision. GPs are independent professionals who may take advice from named or designated professionals if they think it necessary

4.14.2 By definition priority is given to those cases in which there are safeguarding or other statutory concerns. It is understandable that this was not a case that professionals needed to discuss in supervision or with more senior managers because there was no evidence of risk to the children or disagreement between professionals about how to proceed.

4.14.3 At various points tasks were delegated to the staff nurse who worked as part of health visiting team. She reported back her involvement and agreed her next steps with the health visitor leading the team. This is an example of the 'skill mix' approach working successfully, allocating tasks to staff equipped to deal with them within an overall approach to case management.

4.14.4 At no point did the circumstances of this case warrant discussion with a supervisor or manager in any other agency. There is no indication that the lack of supervisory involvement had a negative impact on the case.

4.14.5 There are no specific or additional findings or recommendations in relation to supervision arising from this case review.

4.15 Capacity/Organisational issues

Terms of reference

To establish if there were any capacity issues within agencies that impacted on the quality of the services provided. Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

4.15.1 There is no evidence that lack of capacity or resources or any other organisational issue had any impact on the case. At only one point was this identified as a factor which limited service delivery. There was no antenatal visit to the family by a health visitor prior to the birth of Baby C because these were restricted at the time to families identified as vulnerable. Baby C's family had been defined as not being vulnerable during an earlier health visiting contact. This decision was fully supported by the circumstances of the family and the lack of an antenatal visit had no impact on the pregnancy or the care of Baby C after the birth.

4.15.2 A more important factor limiting the care provided to Baby C by his health visitor was that there was only a limited flow of information from the antenatal service

5 Findings and recommendations of the individual management reviews

5.1 Overview of findings

5.1.1 The SCR panel and the independent overview report author have closely reviewed the content of the individual management reviews and sought clarification of a number of points which have led to amendments in the reports. None of the individual reviews finds evidence of significant shortcomings in professional practice. None finds evidence of missed opportunities to safeguard the children. To different degrees all of the reviews

recognise the potential to learn lessons from the case history and to improve services. These findings are not linked to the death of Baby C

5.1.2 The recommendations that flow from the individual management reviews and the action that will be taken to implement them are set out in the multi-agency LSCB action plan attached to this report.

6 Overall findings of the LSCB review

Terms of reference

What do we learn from the case? Are there lessons from this case for the way in which organisations work to safeguard and promote the welfare of children? Is there good practice to highlight, as well as ways in which practice can be improved? Are there implications for ways of working; single and inter-agency training; management and supervision; working in partnership with other organisations; capacity and resources. Are there implications for current policy and practice?

6.1 This section summarises the findings of the evaluation set out in detail in section 4 above.

The period when the family lived in (redacted)

6.2 The terms of reference of this review focus on the period from June 2010 when Baby C's family lived in Buckinghamshire. The review has obtained background information about the contact that agencies had with the family when they lived in (redacted). The background information from (redacted) indicates that this was a family where the parents experienced some personal difficulties but that there were no indications of any risk of serious harm to the children. Other than through the routine transfer of health records there was no reason for agencies in (redacted) to have alerted counterparts in Buckinghamshire to the fact that the family had moved because there was no indication that the children were at risk. There were delays in transferring health visiting records from (redacted) to Buckinghamshire, but the professionals involved did share relevant information by phone.

The period when the family lived in Buckinghamshire

6.3 Overall the SCR has established that the standard of practice and service provision made to the family and the children when they lived in Buckinghamshire was good. Services were responsive to the identified needs

of the family. This encompassed services relating to homelessness and housing needs, responses to the medical problems of the mother and the responses to the health and developmental needs of the older children.

6.4 There was no record of social care involvement in Buckinghamshire. Two health professionals recall contacting social care 1) for low level practical and financial support and 2) to find out if the family were known because their circumstances seemed unusual. Unfortunately no agency has any record of these contacts. The local authority has been asked to check that its systems for recording such enquiries are working effectively. There is no suggestion that the family was ever referred to social care because of a concern and no question that this was ever merited by the information available to professionals.

6.5 The mother's pregnancy with Baby C was complicated by her underlying heart condition. Health services responded in a flexible way to this and the steps taken ensured that it did not adversely affect her health or the health of the unborn child during pregnancy.

6.6 The mother missed a number of antenatal appointments. The most likely explanation for this was that the appointments were at a hospital and the family had no car, making a journey to the hospital with two small children inconvenient and expensive. The antenatal service took sensible steps were taken to ensure that alternative community based appointments were made and the mother kept these.

6.7 The evaluation has shown that there were points in the case history when there were missed opportunities to coordinate aspects of health provision. These have been listed in section 4.12 above. They arose largely as a result of the fact that health professionals did not routinely consider that it would have been valuable for the family for information about the action that they were taking to be shared with other health professionals. Sharing this information would also have helped professional colleagues in their work. These missed opportunities should be considered as lessons learnt which highlight possible ways in which services can be improved. They did not adversely affect family members and nor did they have an impact on the outcome for Baby C.

6.8 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 appears to be simple. This case history shows that in reality plotting and interpreting this information and deciding what action to take is a complex area 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 could be improved and the individual management review of health visiting services and the health overview report make specific recommendations on this.

6.9 This SCR 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. [8] Health professionals are often the only ones actively working with these children and their families . It is recognised that there are opportunities for improvement in this area of practice and service provision which health providers and commissioners will take into careful account in their future work.

6.10 It remains to be established whether or not Baby C died as a result of a shaking injury. It is known that such injuries can occur in families where there have been no previous concerns as a result of a sudden outburst of anger or frustration at a baby's crying. [9] If legal findings point to this as a possible explanation then it would be appropriate for the LSCB to review the current information and advice that is given to new parents in Buckinghamshire on the dangers of shaking babies.

7 Conclusion

Terms of reference

[8] 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*

[9] http://www.nspcc.org.uk/inform/resourcesforprofessionals/underones/preventing_nahi_wda85611.html

A summative statement of whether agencies had information available to them or whether there were opportunities to intervene which might have led to the death of Baby C being prevented

7.1 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'*. [10] 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.

7.2 The post mortem investigation into Baby C's death has found that he died as a result of a head injury. The nature of the incident that led to the injuries that caused his death is yet to be fully explained. At this point it is not known who was responsible for causing the injuries and what – if anything – any other person knew about what happened. The post mortem investigation identified other injuries to Baby C which can be best dated as happening about two weeks before his death. Similar unknowns exist in relation to these injuries. There is a strong possibility that both sets of injuries resulted from episodes of abuse and at present no alternative explanation has been put forward which would satisfactorily explain them.

7.3 Baby C was seen on seven occasions by health professionals during the 9 weeks of his life. [11] He was also observed less formally on numerous occasions by staff at his sibling's day nursery when his parents dropped off and collected his sibling. The last formal professional contact with Baby C was on 3 October, three weeks before his death. This was with a health visitor who found him to be well, though noting that his rate of growth was slower than would normally have been expected. On 21 October Baby C was seen, but not examined, by a practice nurse when his siblings were taken for immunisations at the family GP surgery. This was the day before he was admitted to hospital with serious injuries. Neither of these professionals saw any indication that Baby C was at risk of serious injury. None of the professionals who saw him during his short life were aware of any injury to

[10] The Lord Laming (March 2009), *The Protection of Children in England – a Progress Report.,* HC330 Stationery Office
[11] Not counting contacts after her hospital admission

him or saw bruising, scratching or any indication of possible physical harm or abuse.

7.4 Thorough review of all of the records gives no indication that any professional missed any evidence or symptom of the kind of abuse that may have caused Baby C's death. On the basis of current knowledge the injuries that Baby C is believed to have suffered approximately two weeks before his death occurred after the last visit made to the family by the health visitor on 3 October 2011. Even if these injuries had occurred during a period when professionals were visiting the family they are very unlikely to have been noticeable unless Baby C had had a full medical examination, and possibly only then if there had been a full skeletal survey (x-ray). At no point were there grounds to indicate to any professional that a full medical examination of Baby C was necessary.

7.5 Baby C's parents had experienced difficulties in their lives but there was no indication at all that the way in which they coped with them or responded to them posed any risk to their children. At different points all three of the children had minor problems in their health and development, but there was no indication at all that these were due to shortcomings in the way in which they were looked after.

7.6 As we now know the cause of Baby C's death it can be seen with the benefit of hindsight that he was at risk of serious harm. However it is still not known who posed that risk or why. There is no evidence that professionals could have identified the risk of serious harm to Baby C during his life and no evidence has arisen during the course of this SCR to indicate that Baby C's death could have been prevented if professionals had acted differently.

7.7 There are of course lessons to be learnt from the review and there are opportunities for development and improvement of services. These will be implemented through the action of individual agencies and the LSCB to implement the recommendations of this report, the individual management reviews and the health overview report

8 Additional recommendations from the LSCB review

8.1 The SCR overview report has identified findings in the following areas pointing to the possible need for recommendations:

a. Arrangements for identification and review of vulnerable families in GP surgeries

b. Promotion of better liaison and working arrangements between Health Visitors, GPs and other members of primary health teams

c. Better use of the antenatal liaison form to ensure that there is more comprehensive sharing of information between antenatal services, GPs and Health Visitors

d. Improving the knowledge that midwives have of relevant history from women's previous pregnancies

e. The need for a consistent national approach to the recording of responses to confidential questioning during pregnancy about domestic violence

f. Improvements in the completion of information (including children's weight) by midwives in Personal Child Health Records

g. Social care - review intake and referral arrangements in relation to the recording of notifications and enquiries

h. Review of the guidance and training provided on the use of growth charts

i. 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

8.2 Items (a)-(f) on this list relate to the provision made by health professionals and have been addressed through the recommendations made within individual management reviews or in the health overview report. As these form part of the integrated multi-agency action plan, they are not repeated here.

8.3 The following additional recommendations are made:

1) Buckinghamshire County Council should check the current functioning of its referral and assessment arrangements to ensure that the system for

recording notifications and 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 through publicising the findings of this SCR and through its wider monitoring and training functions that agencies make professionals aware of the need to reflect on significant changes in parental behaviour (including withdrawal of cooperation and contact) when they are working with children especially where there are grounds to suspect a risk of significant harm.
4) 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.

8.4 The background reports provided by (redacted) LSCB identify a number of potential shortcomings in the provision made to the family in (redacted), though the extent of these and the reasons for them have not been examined in practice as they fell outside of the period covered by the terms of reference of this review. (redacted) LSCB and its member agencies should be invited to review these matters and to decide what further action the board and its member agencies wishes to take, if any.

8.5 The LSCB multi agency action plan is produced as a separate document which will be updated regularly to include progress reports on the implementation of all of the recommendations arising from the SCR. Progress on the implementation of recommendations is monitored closely by the LSCB.

9 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.

Appendix 1

Terms of reference of the SCR

1) To establish the family history available to agencies before June 2010
2) To establish what assessments were undertaken and the quality of those assessments
3) To establish what risk factors were identified in relation to the children
4) To establish if plans were implemented and to what extent the plans addressed any risk factors identified in the assessments
5) To establish if agencies shared information appropriately and involved other professionals or agencies as necessary
6) To establish if assessments took full account of the information available to the agency
7) To establish to what extent the “voice of the child” was heard in terms of understanding the needs of the child and taking account of their experience in the family
8) To establish to what extent the “voice of the siblings” were heard in terms of understanding the needs of the siblings and taking account of their experience in the family
9) To establish if there were factors which enhanced or impeded working relationships with the parents
10) To establish to what extent the parenting capacity of the parents was considered and addressed
11) To establish if the diversity needs within the family were identified and addressed
12) To establish if there were any capacity issues within agencies that impacted on the quality of the services provided
13) To establish if staff involved had the skills, knowledge and experience to address the issues within the family
14) To establish if staff within agencies co-operated to achieve the best outcomes for the children
15) To establish to what extent individual agency and multi-agency policies were adhered to and to comment on the adequacy of those policies
16) To establish if staff directly involved had appropriate supervision and managerial guidance
17) 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
18) Internal Management Review Report writers to identify any additional issues for consideration by the Overview Report writer.

Appendix 2

Membership of the Bucks LSCB SCR panel

Independent Chair	**Donald McPhail**

Agency	**Job title / Designation of SCR panel member**
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

Appendix 3

Sample of centile height and weight chart

(redacted)

Appendix 4

Background documents and references

Brandon M, Belderson P, Warren C, Howe D, Gardner R, Dodsworth J, and Black J (2007) *Analysing child deaths and serious cases through abuse and neglect: what can we learn*? A biennial analysis of serious case reviews 2003-2005. DfES

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P Reder, S Duncan and M Gray, *Beyond Blame – Child Abuse Tragedies Revisited,* Routledge (1993)

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