



**Buckinghamshire Safeguarding Children Board**

**Serious Case Review  
Overview Report  
Executive Summary**

**in respect of**

**Baby D**

**Report Author:**

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# 1 BACKGROUND TO THE REVIEW

1.1 At 10pm on a Saturday night Baby D was admitted to hospital with significant injuries. Following examination, a senior consultant at the hospital reported that the injuries could not have been accidental and informed the police. As a result of this event a subcommittee of Buckinghamshire Safeguarding Children Board met to decide whether the case met the criteria for a serious case review. The committee was informed that an allegation of domestic violence had been made by Mother during pregnancy and this had been known to Thames Valley Police and the GP. There had been no involvement by Children's Social Care prior to the admission to hospital, although information did reveal some concerns about the multi agency response during the weekend immediately following the baby's admission to hospital with the serious injuries. In the light of this information, the committee recommended to the chair of Buckinghamshire Safeguarding Children Board that the case met the criteria for a Serious Case Review as defined within statutory guidance.<sup>1</sup> The chair agreed that a review should be carried out and a serious case review panel was appointed to oversee the review chaired by an independent consultant. An independent overview author was appointed and the business manager for Buckinghamshire Safeguarding Children Board provided support to the process.

1.2 The panel members for this review were:

Chair	Paul Kerswell, Independent Consultant
Designated Doctor	NHS Buckinghamshire
GP representative	NHS Buckinghamshire
Operations Manager Quality Assurance	Buckinghamshire Children's Social Care
Business Manager	Buckinghamshire Safeguarding Children Board
Detective Chief Inspector	Thames Valley Police

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<sup>1</sup> HM Government (2012) *Working Together to Safeguard Children* pages 235 - 236

Senior Educational Psychologist	Buckinghamshire Children's Service
Named Midwife	Buckinghamshire Healthcare NHS Trust
Group Solicitor and Legal Advisor	Buckinghamshire County Council and BSCB
Service Manager Adult Safeguarding	Buckinghamshire Adult Services
Domestic and Sexual Violence Coordinator	Buckinghamshire County Council

- 1.3 The Designated Nurse, NHS Buckinghamshire attended all panel meetings in order to gather information regarding the issues to be explored within the health overview report.

### **Scope of the review**

- 1.4 Following consideration of the known information about the family, the timeframe for this review was set as from the time that Mother became pregnant with Baby D up to and including the Saturday and Sunday that Baby D spent in hospital following the serious injuries. Father had an older child from a previous relationship and the extension of the timeframe to include the period in hospital would allow the review to consider whether all appropriate action was taken to protect both the baby and half sibling at this point.

### **The serious case review process**

- 1.5 Comprehensive terms of reference were set to guide individual management review authors from those agencies who had contact with the family. Reports were requested from:
- Thames Valley Police
  - Buckinghamshire GPs
  - Buckinghamshire Healthcare NHS Trust in respect of community midwifery and health visitor involvement
  - Buckinghamshire Adults and Family Wellbeing in respect of the out of hours service
  - Buckinghamshire Healthcare NHS Trust in respect of hospital involvement pre and post birth.

1.6 All individual management reviews were discussed with authors by the serious case review panel and where necessary the author was asked to supply additional information. The chair of the panel also wrote to the District Crown Prosecutor for information that would assist the panel in understanding why Father was not prosecuted following the allegation of assault by mother. This information was included within the final overview report

1.7 Although the panel were confident by the end of the process that the review had been informed by all the necessary information, the overall review process was hindered by inconsistent attendance at the serious case review panel meetings by staff from Thames Valley Police and Buckinghamshire Adult Services. When no one person consistently attends panel meetings, the thread of the ongoing analysis and reason for additional information requests may be lost. The process of gathering further agency specific information and presenting this to the panel is less efficient and time is wasted revisiting issues for the benefit of attendees who have not been at previous meetings. Ways of improving this for future reviews will need to be considered by Buckinghamshire Safeguarding Children Board.

### **Family Involvement**

1.8 Due to the ongoing criminal investigations, Thames Valley Police asked the panel not to contact any family member for a contribution to the review. The panel agreed that the review should not in any way compromise the criminal process, and therefore at the time of writing there has been no family input into the review.

## **2. PROFESSIONAL INVOLVMENT IN THIS CASE**

2.1 The family had little historical contact with any services other than those provided on a universal basis. Once Mother was known to be pregnant her ante natal care was arranged by the GP surgery and provided by the GP practice in conjunction with the community midwifery service.

2.2 The most significant involvement during pregnancy was at the point when

Mother was twenty three weeks pregnant and reported being assaulted by father. Maternal Grandmother informed the police of the assault on her daughter and they immediately visited mother and began investigating her report. The same day mother visited the GP surgery stating that she had been assaulted by her partner from whom she had now separated and wished to make sure that the baby was Ok. The GP recorded the injuries, which were consistent with an assault and confirmed no harm had come to the baby. Mother told the GP that the police knew about the assault and the GP therefore assumed that they would take the appropriate next steps including signposting Mother to the appropriate support services. Mother was assumed to be safe because she was no longer in a relationship with her partner. The visit was documented in both the patient held record and the computerised GP record which is accessed by the midwives at the clinic. It was therefore the belief of the GP that information had been shared appropriately, although the midwife did not look at the record until several weeks later at the next ante natal appointment. At that point the midwife also recorded that mother and father had separated and took the view that risks were low. Both the GP and the midwife therefore appear to be unaware of research which consistently shows both an increased risk of domestic violence during pregnancy<sup>2</sup> and that the risk of domestic violence increases at the point of relationship breakdown<sup>3</sup>.

- 2.3 Although the GP assumed that all necessary action would be taken by the police it is now clear that not all actions conformed to expected standards. Thames Valley Police had responded promptly to the call from Maternal Grandmother, visited Mother at home, took photos of the injuries and completed a Domestic Abuse Stalking and Honour Based Violence form (DASH). This information was graded as “standard”, the lowest level of risk. One consequence of this grading was that although Mother was referred to the local victim support service, no referral was made to specialist domestic violence services as would have been the case had the DASH assessment been graded “medium” or above.

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<sup>2</sup> Mezey, G and Bewley, S. (1997) ‘Domestic Violence and Pregnancy’ *British Journal of Obstetrics and Gynaecology*. 104. 528-31

<sup>3</sup> Walby, S and Allen, J. (2004) *Domestic Violence Sexual Assault and Stalking: Findings from the British Crime Survey*. Home Office Research Study 276. London: Home Office Research, Development and Statistics Directorate

2.4 The DASH assessment should have been submitted to a supervisor but this did not happen and in addition the unborn child was not added to the police electronic record. Had this been done, an automatic referral would have been triggered to the Child Abuse Investigation Unit and Children's Social Care would have received a notification of the assault. However it is positive that the next morning Thames Valley Police internal systems picked up that there had been no supervisory review. When this took place it was noted that Father should have been arrested in line with the Thames Valley Police positive intervention policy in situations of reported domestic violence. Mother was spoken to again and during this conversation she agreed to support police proceedings. A detailed statement was taken from Mother confirming the allegations that had been made the previous day including specific injuries. Father was arrested and released on police bail with conditions aimed at protecting mother from further assault.

2.5 All relevant information was sent to the Crown Prosecution Service who, a month after the reported assault (1<sup>st</sup> July), decided that although the level of Mother's injuries was consistent with an offence of battery there was insufficient evidence to proceed. Their decision was based on the fact that both Mother and Father had injuries. Mother's friend who had been with her at the time of the incident accepted that she had not seen events in their entirety and Father's account, supported by Paternal Grandfather and a friend, suggested that Father had acted in self defence. Therefore due to a conflict in the evidence it was decided that there was no realistic prospect of securing a conviction and Father was released from his conditional bail.

2.6 As the pregnancy progressed there were a number of opportunities for community health staff to identify that mother and Father had resumed their relationship, yet this did not trigger any further assessment of risk in the light of the previous assault. Mother also attended hospital seven times with various pregnancy related symptoms and again there is no evidence that the records were reviewed and the previous assault taken into consideration when assessing Mother's needs.

- 2.7 Following the birth of Baby D there were no post natal concerns apart from one brief hospital admission at five days old with loss of weight, dehydration and jaundice. It was at just over eight weeks old that Baby D was admitted to hospital in the early hours of Sunday morning with serious injuries which were considered by the consultant to be non accidental. Baby D received good medical care and the consultant appropriately informed the Social Care out of hours team about the injuries and that father had a two year old child from a previous relationship. Instead of taking the lead and commencing enquires under sec 47 of the Children Act 1989 the out of hours social worker asked the consultant to inform the police. In the view of the social worker that the situation was “more important than a S47”, potentially a criminal matter, the baby was safe in hospital and could be protected using police protection powers. No guidance was sought from a manager and the response indicates a worrying lack of understanding regarding child care legislation and statutory guidance.
- 2.8 As soon as they were informed of the injuries, officers from Thames Valley Police Child Protection Unit visited the hospital ward, interviewed the parents and advised medical staff that no relatives were to be left unsupervised with Baby D. The next morning the police asked the out of hours social worker to attend a strategy meeting but the social worker did not feel able to leave their base in case there was another emergency. The picture was further complicated by the fact that the out of hours team were not able to review records since the computer system was “down” for routine maintenance.
- 2.9 Again the out of hours social worker did not contact a manager for advice but instead contacted a colleague. The lack of contact with a manager appears to have been linked to the culture of the service where workers were expected to work with a high degree of autonomy as well as no formal arrangements being in place for on call managers with child care experience. The emphasis on autonomous working was not backed up by a high level of knowledge and skill on child care matters, in contrast with the higher level of knowledge and expertise of out of hours workers in the mental health field.

- 2.10 The police were asked by the social worker to obtain the parent's agreement that they would not visit the child unsupervised pending a strategy meeting being convened on Monday morning. The police expressed their concern at the lack of Social Care involvement and later that morning met with the consultant paediatrician to ensure that the hospital were clear that all access to Baby D had to be supervised by a member of staff. Later on Sunday, police protection powers were used in respect of both Baby D and Father's two year old child. Baby D remained in hospital supervised by ward staff and father's oldest child remained with their mother with an undertaking from the family that father would not be allowed to visit.
- 2.11 The out of hours worker on the last shift of the weekend was asked to send an e-mail to the referral and assessment team before the start of the working day on Monday to alert them to the need for an urgent strategy meeting. This e-mail was not sent and it was only when the police contacted the referral and assessment team on Monday morning that they were aware of the events over the weekend. The staff member responsible for sending the e-mail cannot recall why the slip occurred other than it was possibly due to having to go out on a Mental Health Act assessment. In addition they were relatively new to the team and it was their first experience of computer systems being unavailable.
- 2.12 Thames Valley police indicated that they would be making a formal complaint about the actions of the out of hours team but to date this complaint has not been made.

### **3. WHAT CAN WE LEARN FROM THIS CASE?**

#### **Recognising and responding to domestic violence**

- 3.1 A key feature of this case is the lack of confidence across health professionals in recognising and responding to domestic violence. Exploration of *why* this is the case points to a lack of knowledge in relation to domestic violence, despite research that has been available for a number of years pointing to risks associated with pregnancy and separation.

- 3.2 Lack of knowledge led to inappropriate assumptions being made which in turn resulted in missed opportunities to engage fully with Mother and understand any potential risks to the unborn child. For example, assumptions were made by the GP that because Mother reported separating from her partner she was safe and that the police would deal with all investigation and support needs. These assumptions led to a belief that there was no need to discuss the situation with the practice lead for child protection or the community midwife. When the community midwife did become aware of the assault the same assumptions were made. The lack of focus on the implications of the assault on mother whatever the circumstances of her relationship meant that the significance of information indicating that mother and father were once more together became lost.
- 3.3 Thames Valley Police did not focus on the unborn child as a potential victim or fully evaluate all risk factors when completing the DASH assessment. With hindsight, the list of factors present in this case would seem to indicate clearly a high risk of domestic violence yet, when the Domestic Abuse Stalking and Honour Based Violence (DASH) assessment was completed the risk was identified as “standard”, the lowest level of risk. Factors such as pregnancy and separation were not those which automatically moved the assessment into a higher level and the final assessment relied on the knowledge and experience of the individual completing the form. As a result of this serious case review Thames Valley Police have now instructed that where the victim is pregnant the risk should always be assessed as at least “medium”. This will also ensure that a safety plan is in place including referral to specialist support services.
- 3.4 The recommendation that pregnancy should always raise the level of risk to medium will help as will ensuring that up to date knowledge is embedded across the professional community through training. However training alone will not improve practice and there will also need to be ongoing evaluation of the impact of training on practice decisions.

**Effective assessment and multidisciplinary working in the ante natal and post natal periods.**

- 3.5 The individual management review reports completed by health organisations highlight that the medical care received by Mother and Baby D was of a high standard throughout. However, the focus was on medical intervention, and there were lost opportunities to understand the social circumstances of the family and how these may impact on parenting capacity. As explored above, this was particularly significant in relation to domestic violence, although it is clear that generally practice across health agencies did not prompt practitioners to undertake a holistic assessment of Mother's circumstances. In common with many other serious case reviews, limited information was ascertained or recorded in respect of father, with the focus of ante natal and post natal care being on the medical needs of mother and the baby. Moving from the traditional medical model to one which facilitates a more holistic approach will involve a culture shift within midwifery, obstetric and general practice.
- 3.6 The health overview report poses the question as to whether there would be more focus on safeguarding within primary health care meetings if, similarly to palliative care, there were Quality and Outcomes Framework points awarded for regular discussions of vulnerable families. As identified by the Munro review, targets can have unintended outcomes which skew responses and detract from a focus on the individuality of each case. Perhaps the most appropriate way forward is therefore to improve the way in which professional judgement is exercised and build capacity and understanding across the multi professional partnership.
- 3.7 Information sharing across health did not always facilitate effective multi-disciplinary working. It is clear from this case there may be little face to face discussion between professionals and that the reliance on written records for information sharing has limitations. Ways need to be found to facilitate face to face discussions and the potential importance of GP practice meetings in enabling this to happen has been identified within this review .
- 3.8 There is a consistent theme relating to a lack of clarity about which professional should be taking the lead at various stages of work in this case. It is clear that the GP did not take a proactive approach in relation to the domestic violence

report and assumed the police would be leading the response both in relation to the investigation and ensuring the necessary support services were in place. The underpinning reason for this lack of clarity appears to have been rooted within a misunderstanding of the system that is in place to respond to victims of domestic violence as well as the nature of domestic violence itself.

- 3.9 The confusion over the lead professional was particularly apparent after the serious injuries when the out of hours social work team did not recognise their role in conducting section 47 enquiries and the hospital staff were left in a vulnerable position with no clearly documented plan for ensuring Baby D was kept safe. The reasons for this are multiple and are addressed in the section below

### **The role of the out of hours service in child protection**

- 3.10 It is clear from this review that the out of hours service should be in a position to fulfil their statutory role with children and families including working collaboratively with the police and health agencies. In this case this did not happen for a variety of reasons including:

- The perceived role of an out of hours service both within the team, by partner agencies and the ‘fit’ between role and legislative requirements. (i.e. is the role of the team to “hold” situations or to provide a full child care service?)
- Capacity issues within the team.
- The knowledge and skills of the staff in relation to child care work.
- Access to management support and advice.

- 3.11 The issues that have emerged from this review are informing an extensive review of the out of hours service which will aim to clarify expectations and ensure the service is fit for purpose. In addition Buckinghamshire Safeguarding Children Board took immediate action to instigate an audit of children’s work within the out of hours service in order to inform future work plans.

### **Professional Challenge**

3.12 Thames Valley Police were unhappy about the quality of multidisciplinary working with Social Care out of hours service following the injury. Where one agency is concerned about the actions of another it is important that steps are taken as soon as possible to have a full and frank dialogue in order to understand each other's perspective and ensure that high quality services are delivered to children and their families. Wherever it is impossible to resolve issues, official processes such as complaints procedures may need to be used. Although the police were clearly concerned about the level of response from Social Care over the weekend there is no evidence that they considered how best to escalate these concerns either at the time or later. In fact there has been a degree of confusion regarding at what point the police decided not to make an official complaint and the rationale for this decision.

## **7 CONCLUSION**

7.1 At the time of writing it is not known how the injuries to Baby D occurred, although there is reasonable cause to believe that they were non accidental in nature. The general picture that has emerged from this review is of a pregnancy that was labelled as low risk. There was, however, one significant lost opportunity to identify potential risk to the unborn child as a result of domestic violence when mother visited the GP with injuries and also reported a domestic violence incident to the police, whose response did not take adequate account of the potential impact on the unborn child. Links between domestic violence and child protection are well documented within the literature<sup>4</sup> yet did not inform the thinking of health professionals nor the police response.

7.2 At the time of the serious injuries it is clear that Baby D received good care within hospital but the child protection response by the out of hours team was not compliant with either legislation or statutory guidance. This left the hospital staff in a vulnerable position with no clear documented plan, as well as insufficient attention being paid to the safety of other children within the extended family.

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<sup>4</sup> For an overview see Cleaver, H. Unell, I and Aldgate, J (2012) *Children's Needs- Parenting Capacity: Child Abuse: parental mental illness, learning disability, substance misuse and domestic violence 2<sup>nd</sup> edition*. London: The Stationary Office

## **8. OVERVIEW REPORT RECOMMENDATIONS**

- 8.1 Buckinghamshire Safeguarding Children Board should ask the Chief Executive of Buckinghamshire County Council to confirm that the service is “Climbié compliant”.
- 8.2 The Domestic and Community Violence Strategy Group should review the guidance notes for all agencies for the completion of the DASH form so it is consistent with the police recommendation that pregnancy automatically results in an assessment of risk as at least "medium".
- 8.3 Buckinghamshire Safeguarding Children Board should evaluate the effectiveness of domestic violence training across partner agencies.
- 8.4 Buckinghamshire Safeguarding Children Board should require Thames Valley police to ensure that where they have concerns about the safeguarding practice of another organisation the regular complaints and/or escalation process is always used. All partner agencies should be reminded that the serious case review process is not a substitute for appropriate challenge of poor practice.
- 8.5 All partner agencies should be reminded of their responsibility to signpost victims of domestic violence to appropriate specialist support services and report to BSCB regarding the steps taken to ensure that this responsibility is embedded in practice.
- 8.6 Buckinghamshire Safeguarding Children Board should remind all partner agencies of the need for the consistent attendance of one named representative at serious case review panel meetings and set up a system for monitoring compliance with this request in the future.

## **9. HEALTH OVERVIEW RECOMMENDATIONS**

- 9.1 NHS Buckinghamshire will promote and support GP surgeries to adopt the RCGP guidelines on domestic abuse or develop specific practice guidelines on domestic abuse.
- 9.2 Primary care and midwifery services to develop a universally agreed protocol for where and how information on domestic abuse is recorded and shared with the multi-disciplinary team.
- 9.3 NHS Buckinghamshire to seek assurance from all health providers that staff across the health sector have access to domestic violence training.
- 9.4 NHS Buckinghamshire should disseminate to all GP practices examples of PHT meetings that facilitate good multi-disciplinary working aimed at improving outcomes for vulnerable children and their families.

## **10. INDIVIDUAL MANAGEMENT REVIEW RECOMMENDATIONS**

### **Adults and Family Wellbeing – (Out Of Hours Emergency Social Work Team)**

- 10.1 Ensure that there is a clear understanding of the Climbié requirements which the OOH service has to comply with.
- 10.2 Agreement to be achieved between Partner Agencies & OOH team as to the level of service required - this should be formalised in an SLA.

Guidance to be produced which defines by good practice examples the boundaries of managerial decision making and professional judgement to guide staff.

This document will be discussed with and agreed to by key partner agencies and then with the adults and children's safeguarding boards

- 10.3 OOH Remit document to be reviewed by Service Manager – Safeguarding Adults and Family Wellbeing, and strengthened with a list of examples of what OOH does do and type of involvement. The document will also outline principles in relation to the prioritisation of work in relation to emergency and urgent work.
- 10.4 An agreement to be reached to increase the availability of the AMHP service which in turn will reduce the demand on the OOH team and increase capacity.
- 10.5 To provide an additional ‘first response’ to the out of hours team between midnight and 9 AM.
- 10.6 Work to be undertaken to ensure resourcing and capacity of the OOH Team are in line with the agreed remit and role of the team and the SCR findings.
- 10.7 That BCC and partner agencies are fully informed of improvements to OOH capacity and timing and how this relates to the remit of the team and findings of the Serious Case Review.
- 10.8 A statement to be produced which sets out how the capacity enhancing options relate to the general remit of the team and more specifically the risks identified in the Team Manager review of the OOH service and the findings of this IMR.
- 10.9 A review will take place of the fitness for purpose of existing Management Support arrangements for the OOH Team.
- 10.10 To independently review the training and knowledge of the Team in relation to the Children’s Act and taking into account additional training currently being undertaken and in line with the agreed role of the team.
- 10.11 To review existing guidance on work procedures for OOH staff, with support from Business and Systems team.
- 10.12 Jointly commission a Risk Assessment exercise on availability of ICT systems and services to OOH team. This will involve close working with ICT staff in

developing improvement actions which cover planned and unplanned reductions in functionality.

- 10.13 A straightforward logging system for ICT availability, impact and effectiveness of contingency planning should be put in place to record issues occurring when planned or unplanned reductions in functionality occur.
- 10.14 Work log to be subject to a heightened level of scrutiny when there are significant reductions of ICT functionality to ensure effective handover of work to day teams has taken place.
- 10.15 ICT advice sought on the most effective way for the OOH team to implement telephone conferencing.
- 10.16 To review and improve the operation of current recording and information transfer arrangements.  
  
To review the operation of revised/improved systems and processes in practice.

**Buckinghamshire Healthcare NHS Trust (Maternity & Health Visiting)**

- 10.17 Buckinghamshire Healthcare NHS Trust (BHT) to undertake a review of the Maternity Domestic Abuse Guidelines.

*Commenced February 2012 (interim guidance made available to all staff in maternity)*

- 10.18 BHT to update the current Domestic Abuse Training for staff within the Maternity Unit.
- 10.19 BHT Staff to access the Domestic Violence Training (including use of DASH form) within Maternity.
- 10.20 BHT will ensure a structured framework is developed for liaison between professionals.

- 10.21 BHT to promote and support practitioners in assessing the role of fathers and other significant family members and to include as part of any 'risk assessments'

**Buckinghamshire Healthcare NHS Trust (Hospital)**

- 10.22 BHT will ensure an effective mechanism to help doctors capture/review the social/family circumstances at the time of each hospital attendance.

**NHS Buckinghamshire – GP**

*GP IMR surgery specific recommendations:*

- 10.23 Primary Health Care Team (PHCT) meetings will include health visitors and midwives.

- 10.24 The provision of antenatal care at GP Surgery 1 will be reviewed.

- 10.25 Any mention of domestic violence, even if only alleged, to any member of the PHCT should be discussed at PHCT meetings

- 10.26 This case should be discussed at the surgery's next Significant Event Review Meeting.

*GP IMR General recommendations:*

- 10.27 Child Protection Training for GPs across Bucks to be reviewed, including raising awareness of Pre-Birth Procedures.

- 10.28 General Practitioners should be encouraged to undertake the new online training developed by the RCGP regarding Domestic Violence

- 10.29 Midwives and Health Visitors will be invited and enabled to attend every Surgery's Primary Health Care Team Meeting

**Thames Valley Police**

- 10.30 That a review is conducted of the current system for recording unborn children

on CEDAR to establish a formalised process here. This will need to include a review of the Crystal report generation parameters to identify a way that domestic abuse offences involving unborn children are captured in the data provided to partner agencies.

- 10.31 The Domestic Abuse Policy & SOP2 be updated to give clear instruction that any unborn child being carried by a victim of domestic abuse be classified as 'involved' in the incident and as such the following actions are required to ensure appropriate notifications are triggered:
- Record the unborn child's details in the CEDAR Person Screen
  - Amend the CAIU Flag on CEDAR to 'YES'
  - Grade the DASH risk assessment as 'Medium'
- 10.32 TVP implement an awareness campaign reminding staff that unborn babies are children for the purposes of 'Safeguarding' and as such must be identified and referred to the CAIU accordingly – This would include updating existing training packages and developing a comprehensive communication strategy.
- 10.33 Better use should be made of the TVP email system, to allow sergeants to quality assure the DASH risk assessment form electronically as opposed to the current reliance on a 'wet' signature.