Buckinghamshire Safeguarding Children Board

Serious Case Review

Overview Report

in respect of

Baby D

Report Author:

Jane Wonnacott

BA MSc MPhil CQSW AASW

In-Trac Training and Consultancy Ltd

CONTENTS

1 INTRODUCTION

1.1 This serious case review has been carried out by Buckinghamshire Safeguarding Children Board following the admission of an eight week old baby (known in this report as Baby D) to hospital at 10pm on a Saturday with significant injuries. A senior consultant reported that that the injuries could not have been accidental and as a result, the case is currently subject to criminal proceedings.

1.2 The case was reviewed by a subcommittee of the LSCB within six working days of the baby's admission to hospital. Significant family members were identified as:

Mother of Baby D
Maternal Grandmother

Father of Baby D (not living with Mother)
Paternal Grandmother

Father's previous partner
Father's child living with previous partner

1.3 The safety of Father's first child was considered and it was noted that following the incident his previous partner agreed that she would not allow Father or Paternal Grandmother to have unsupervised contact with his oldest child. Further information was obtained from the hospital to confirm that the injuries were life threatening.

1.4 Information indicated 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.

1.5 The decision to conduct a serious case review was made by the Chair of Buckinghamshire Safeguarding Children Board eight working days after the first meeting of the LSCB subcommittee. The reason for the review was:

A child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect;
and
the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.
(Working Together 2010 page 235 - 236)

1.6 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.

1.7 This report has been prepared by Jane Wonnacott, Independent Consultant. Jane qualified as a social worker in 1979 and has an MSc in social work practice and the Advanced Award in Social Work. She has an MPhil as a result of researching the impact of supervision on child protection practice. She has been providing a training and consultancy service in the field of child care since 1994 and, to date, has completed over fifty single agency or overview reports for Area Child Protection Committees/Local Safeguarding Children Boards. She completed the Government of London/Tavistock accredited training for serious case review chairs and overview authors in 2010.

1.8 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
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

1.9 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.

Terms of reference and scope of the review

1.10 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. 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.

1.11 The terms of reference for the review were agreed as:

1. To establish the family history, including the grandparents, available to agencies before Mother's pregnancy was confirmed

2. To establish what assessments were undertaken and the quality of those assessments

3. To establish if assessments took full account of the information available to the agency

4. To establish whether risk factors were identified in relation to the children

5. To establish if the registration of the parents with different GPs impacted on the identification of risk factors

6. To establish if plans were implemented and to what extent the plans addressed any risk factors identified in the assessments

7. To establish if agencies shared information appropriately and involved other professionals or agencies as necessary

8. 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

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 if there was appropriate communication and cooperation on issues of domestic abuse

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

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

18. 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

19. Individual Management Review Report writers to identify any additional issues for consideration by the Overview Report writer.

The serious case review process

1.12 Individual management reviews were requested from:

- Thames Valley Police
- Buckinghamshire GPs
- Buckinghamshire Healthcare NHS Trust in respect of community midwifery and heath visitor involvement
- Buckinghamshire Adults and Family Wellbeing in respect of the out of hours service

1.13 Following consideration of the initial information it was clear that a separate individual management review would be needed in respect of hospital involvement and this was therefore requested from:

- Buckinghamshire Healthcare NHS Trust in respect of hospital involvement pre and post birth.

1.14 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. Following discussion with the senior investigating officer (SIO), it was agreed that in order to prevent prejudicing the criminal investigation the Thames Valley Police individual management review would not contain a full analysis of the events post injury.

1.15 Appendix 1 contains an evaluation and outline of the key learning points within each individual management review. This specific organisational learning has been used to inform the analysis within this overview report.

1.16 In addition to the information contained within the Thames Valley Police individual management review, the panel wished to understand the decision by the Crown Prosecution Service not to prosecute Father following a reported assault on Mother whilst she was pregnant. The chair of the panel wrote to the District Crown Prosecutor and their response is referred to later in this report.

1.17 As a result of the consideration of the individual management reviews it also became apparent that in order to fully understand all the issues in this case more information was needed regarding the structure and operation of the

Buckinghamshire Out of Hours Service; in particular, the Panel needed to understand its ability to comply with the practice requirements of the Victoria Climbié Enquiry (2003). The service had been re-structured in April 2011 and in respect of this, information was sought with regard to:

- What risk assessment had been carried out?
- The impact of this risk assessment.
- Contingency plans that were put in place.
- Communications/consultations with the Buckinghamshire Safeguarding Children Board regarding the proposed restructure.
- Communications/consultations with partner agencies regarding the proposed restructure.
- A description of arrangements for direct management support, supervision and decision making for Out of Hours workers on duty, including a sample of the management support rota to duty workers.
- Any appraisal of skills and knowledge required by Out of Hours workers, including any audit of existing workers and training plans to address any deficit.
- Any statement or evidence of "Climbié Compliance".

1.18 The reply to this request for information is appended to this report.

1.19 In addition to the above request, the Buckinghamshire Safeguarding Children Board took the decision to carry out an immediate audit of twenty Out of Hours referrals involving child care matters including:

- Eight referred from the Out of Hours service to daytime services as child protection.
- Eight child care referrals from professionals which might have the potential for child protection intervention.
- Four referrals from non-professionals.

1.20 This aim of this audit was to:

- Consider the appropriateness of responses: categorisation, information gathering; assessment process.
- Examine evidence of consultation – including management oversight and

supervision.

- Consider the timeliness of the response.

1.21 The above prompt action demonstrates clearly the active role that the Safeguarding Children Board in Buckinghamshire takes in carrying out their responsibility to monitor and evaluate the effectiveness of safeguarding practice in their area. (Working Together 2010 page 93).

1.22 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.

Parallel Processes

1.23 During the process of this review there have been concurrent criminal investigations.

1.24 One impact of the ongoing criminal proceedings had been that the police individual management review author had been directed to limit the analysis of events post injury in order not to prejudice any forthcoming trial.

1.25 There are ongoing Care Proceedings and Baby D has been placed in a friends and family placement.

Family Involvement

1.26 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.

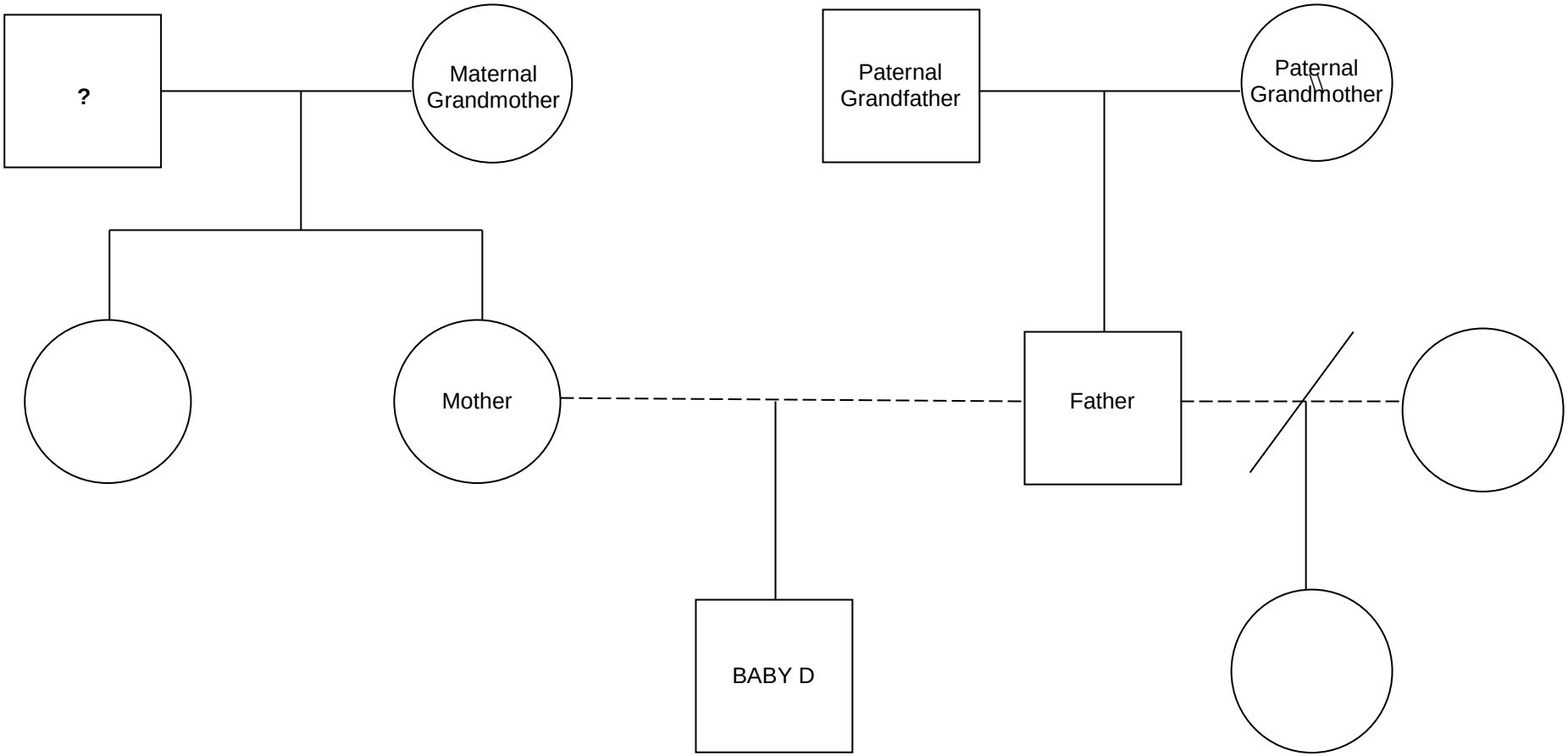
Publication

1.27 It is an expectation of Government Ministers that serious case reviews will be published in full *unless there are compelling reasons relating to the welfare of children directly involved in the case for this not to happen* .[1] Buckinghamshire LSCB will therefore give full consideration to the publication of this report at the appropriate time.

[1] Letter from Tim Loughton 10th June 2010

2. FAMILY CONTEXT

2.1 **Genogram**



2.2 The review involves a family who are described as White British and were brought up within the local community. They have had minimal involvement with agencies beyond those providing universal services. All individual management review authors reviewed records in order to establish whether there was any significant history prior to the start of the terms of reference. Thames Valley Police had had some previous limited involvement with Father and there had been one contact with Children's Social Care when Father was a child. There was nothing within the records that could have been deemed significant in terms of understanding the injuries to Baby D and therefore needed further exploration.

3 PROFESSIONAL CONTEXT

3.1 The family had little 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, which comes under the auspices of Buckinghamshire Healthcare NHS Trust. Health Visitor provision also comes under the same Trust.

3.2 Hospital-based care was provided by two hospitals within Buckinghamshire Healthcare NHS Trust. Hospital 1 provided day assessment clinics and Hospital 2 in-patient services.

3.3 The Social Care Out of Hours service was provided by Buckinghamshire County Council Adult and Family Wellbeing Directorate. Social workers usually provide out of hours cover from their home base, with contact via computer to relevant secure databases and records that they require to do their job. On the weekend relevant to this review the remote access to computerised systems was not available due to routine maintenance, and all staff worked from an office base. This allowed some minimal access to records but at no point over the weekend could staff look up children, family or adult information via the Swift and ICS databases.

3.4 Following a review of the out of hours' service the team was reduced from eight qualified social workers to five as from 1st April 2011. This means that there is

only one qualified social worker on duty at any one time and the team manager is also a practitioner covering some shifts. A recent paper was prepared by the team manager and presented to senior managers from Safeguarding, Adults and Family Wellbeing and Children and Young People's Services, noting that there could be a risk that "excessive demands at peak times cannot be managed safely".

3.5 Although social workers providing the out of hours service are qualified and experienced, not all have extensive child care experience or training. Management support to the team is provided by the team manager and if they are unavailable (or indeed are the worker on shift), the service manager for safeguarding within the Adults and Family Wellbeing Service can be contacted. There is no formal on call management system. There is access to legal advice twenty four hours a day, a service provided on a goodwill basis by Buckinghamshire County Council lawyers, although it would be expected that out of hours workers would first seek advice from an operational manager within children's services when legal action might be considered.

4. PROFESSIONAL INVOLVEMENT WITH BABY D

4.1 Mother attended the GP surgery (27th January 2011) and was confirmed to be in the early stages of pregnancy. She was referred to the ante natal programme at the surgery and subsequently attended for routine appointments.

4.2 The booking appointment with the midwife took place in the surgery when Mother was ten weeks five days pregnant (10th March); this is within the twelve weeks recommended within the NICE guidelines.[2] Mother attended this appointment on her own and information for the "hand held notes" was completed as well as the "booking history". Father was documented as living at a separate address to mother. No risk factors were identified of a medical or social nature and the impression of the midwife was that Mother was happy with the pregnancy and Father was part of her life, despite them not living together.

[2] NICE (2008) Ante natal guidelines – CG62 www,nice.org.uk

There is an expectation that at this appointment a routine enquiry would be made about domestic violence. There is no evidence that this occurred and the individual management review process has highlighted that at that time there was no universal agreement within the Trust as to how to record the fact that the question had been asked and any relevant response. This has now been rectified and it would now be clear within the patient held record whether the question had been asked and whether the response raised any cause for concern. All staff have been made aware of their responsibilities to make routine enquiries, and a domestic abuse training programme is in place which includes presentation/recognition/asking the question/disclosure and management.

4.3 The issue relating to domestic violence is particularly relevant to this review because when Mother was twenty three weeks pregnant (2nd June 2011) she attended the GP surgery stating that she had been assaulted by a male. Although details were not recorded in the notes, the GP recalls that they were "pretty sure she said it was her partner". Mother said that she had gone to see the GP to make sure the baby was OK. The GP carried out an examination, recorded the injuries, which were consistent with an assault and confirmed no harm had come to the baby. The recording of this event within the hand held records noted an "alleged" assault and the advisability of recording the event in this way has been discussed by the serious case review panel and the health overview author, since it is possible that this could put Mother at increased risk should it be seen by her partner. The use of the term "alleged" could also give mother the message that she was not believed; "reported assault" might therefore have been preferable. A recommendation within the health overview report identifies the need to develop a universally agreed protocol for where and *how* information on domestic abuse is recorded and shared with the multidisciplinary team. This will be an opportunity to debate and clarify this issue.

4.4 The GP assumed that since Mother had said the police were aware of the assault, they would take the appropriate next steps. The assumption was also made by the GP that Mother was safe since she was staying at her mother's house and the relationship with Father had ended. Since the visit to the GP was documented in not only the patient held record but also the computerised GP

records (accessed by midwives when at the clinic), the GP believed that the information had been shared appropriately. In fact the midwife did not look at the records until several weeks later at the next ante natal appointment.

4.5 Although the GP had assumed the police would take the necessary action, information from the Thames Valley Police individual management review indicates that their response fell short of the expected standard. Thames Valley Police had been contacted by maternal grandmother on the same day that Mother had attended the GP surgery (2nd June 2011), giving information that her daughter (five and half months pregnant) had been involved in an incident that morning with her boyfriend. Mother was described as having gone to father's house asking for the return of some belongings after "falling out" with him, having found him with another woman in the pub the previous night. During that incident Mother was described as having slapped Father around the face. When Mother removed her belongings from Father's home in the morning they had an argument and Father was reported to have flown at Mother's throat, smashed her head against the car and left marks on her neck. Maternal Grandmother told the police that Father had hit a previous girlfriend when she was pregnant. Despite this information there is no indication that at any stage in the subsequent police enquiries consideration was given to the possibility that Father had contact with a previous partner and their child.

4.6 Within an hour of the call from Maternal Grandmother a police officer attended Mother's home and spoke to Mother. Mother did not want to "press charges" as she was concerned that this may have implications for Father's willingness to contribute financially to the child's upbringing. In the light of Mother's wishes a witness statement was not obtained although the officer did take photographs of the injuries to her neck and face which he later detailed in his evidential statement. The officer completed a Domestic Abuse Stalking and Honour based Violence form (DASH) and graded the information as "standard", the lowest level of risk. This assessment should have been submitted to a supervisor but this was not done, and 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. It was later that day that Mother attended the GP surgery to check the baby's wellbeing.

4.7 The next morning (3rd June), 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. In addition Mother described sustaining the following injuries;

- Deep red bruises on her neck
- Very painful neck similar to whiplash
- Two bumps on her head
- Bruising on her nose
- Bruising to the lower part of her jaw
- Some of her hair pulled out.

4.8 No statement was taken from the GP who had seen the injuries. It would have been good practice on the part of the Police to have done so, especially since the GP would have been able to confirm that the injuries appeared consistent with an assault. A statement was, however, taken from Mother's friend who had been with her at the time, confirming the above.

4.9 The police officer referred Mother to the local victim support scheme. Police records confirm that Victim Support made contact with her a couple of days after the incident via a telephone call. Mother declined any assistance from Victim Support and therefore no further contact was made. There was no signposting to specialist domestic violence support services by any agency.

4.10 Later that evening Father was arrested on suspicion of Assault Occasioning Actual Bodily Harm. In his statement Father claimed he was acting in self-defence as Mother was punching and slapping him. Father was given bail with the conditions that he should not contact Mother directly or indirectly and he should stay away from her address.

4.11 Further statements were taken from Father's work colleague who witnessed the event, as well as Paternal Grandfather who had been looking out of his bedroom window. Both statements confirmed there had been a confrontation and that both Mother and Father had been involved.

4.12 All relevant information was sent to the Crown Prosecution Service who, a month after the reported assault (1st 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. Father was therefore released from his conditional bail.

4.13 Although the GP had felt that appropriate information regarding the assault had been shared with the midwife, in fact it was four weeks later before the Mother was seen by a midwife (30th June) and there had been another appointment with a GP in the meantime. At the midwifery appointment the notes record "*stressful split from partner"* and the midwife cannot now recall whether she discussed the assault with Mother at that stage. In interview for this review the midwife commented that in any event, in the light of the split from Father, had the assault been discussed, she would have assessed risk as 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[3] and that the risk of domestic violence increases at the point of relationship breakdown[4].

4.14 Nine days after the midwife had noted the split from her partner, Mother was admitted to hospital in the early hours of the morning with a post-coital bleed.

[3] Mezey, G and Bewley, S. (1997) 'Domestic Violence and Pregnancy' *British Journal of Obstetrics and Gynaecology.* 104. 528-31
[4] 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

The hospital records note that she was accompanied by her "partner" who was assumed to be Father. Appropriate medical care was given in respect of this event, and a letter sent to the GP. However, there is no indication that the triage midwife or the obstetrician took note of the comments entered in the hand-held records by the GP regarding the assault, or the note by the midwife regarding the split from her partner. The reason for admission and presence of her partner at the appointment should have prompted further enquiries in the light of the comments in the notes one month previously.

4.15 When Mother was twenty eight weeks+six days pregnant (14th July) a further hospital admission occurred for one night with pregnancy related symptoms, including lower back pain and stomach cramps. There was no note on the records of who accompanied her on this occasion. Subsequent routine ante natal appointments confirmed that the baby was growing well.

4.16 A further referral to hospital by the community midwife took place when Mother was thirty six weeks+five days pregnant (6th September) with Mother reported to be feeling unwell and the baby's movements decreased. Following assessment she was discharged home. There is no record of any social history within the notes.

4.17 Mother was seen three more times by health staff prior to an admission to the labour ward. One of these occasions (19th September) was a self-referral to the Day Admission Unit complaining of headaches, visual disturbances and not feeling the baby move. This was the fifth attendance at hospital and the midwifery individual management review notes that "vague unresolved admissions to ante natal wards can be associated with domestic violence". Although she was not admitted on every occasion, Mother's pregnancy was characterised by frequent contact with hospital services. This was not commented on or explored at any time by any health professional within the context of the documented previous assault by Father.

4.18 Following admission in early labour (20th September) Mother was sent home, reviewed two days later (22nd September) and eventually readmitted the next day (23rd September). Although Mother could have returned home she was not

keen to do so and it was decided to transfer her to the ante natal ward. A note was made in the records that she "*has had 7 admissions during pregnancy*".

4.19 Mother gave birth to a baby boy (23rd September) and the medical records note that she was receiving good support from her mother and partner. Following the birth Mother and baby were discharged home the next day.

4.20 Following routine post natal care Baby D was admitted to the paediatric ward at Hospital 2 at five days old due to having lost 15% of his birth weight, dehydration and jaundice. Hospital records note that the parents were not married but were living together with good support from Maternal Grandmother. Baby D remained in hospital for forty eight hours and was discharged home "with parents". A follow up appointment the next day confirmed weight gain was good.

4.21 Mother was discharged from the care of the community midwife when Baby D was thirteen days old (6th October), and the health visitor was informed of the transfer of care via an answer- phone message. A primary new birth visit was made by the heath visitor eighteen days post-delivery. At this visit mother told the health visitor that father had a two year old child with whom he had regular contact, but he was supportive of her and the baby. Routine GP and health visitor contact followed and at six weeks Baby D was seen by both the GP and the heath visitor. He was reported to be well and happy. The GP had measured his head circumference and when doing so did not notice any concerning bumps or marks.

4.22 When Baby D was eight weeks and two days old he was admitted in the early hours of Sunday morning to Hospital 2 with injuries which were thought to be non-accidental. Both parents accompanied the baby, who was noted to live with Mother, Maternal Grandmother and Aunt. Father was noted to live with his parents and to have a child from another relationship. The history given was that Baby D had been left with Father whilst Mother, Maternal Grandmother and Aunt went to the cinema. Father had noted a swelling on the baby's head and sent a text to Mother. He also sought advice from his mother (Paternal Grandmother), and when Mother returned from the cinema she was very concerned by the swelling and they decided to take Baby D to Accident and Emergency.

4.23 Appropriate medical care was given to Baby D which is well documented within the medical records. Injuries to the skull and fractures to both legs were recorded. Mother asked a trainee doctor what the scan had showed and when informed of the nature of the injuries appeared very shocked and upset. Both parents were subsequently spoken to by the paediatric consultant who explained that the injuries must have been caused by a person.

4.24 The out of hours team (OOH worker 1) were advised of this admission by the paediatric consultant at 2am. The hospital records note that the social worker was informed that Father had a two year old child from another relationship who lived with their mother. The out of hours worker recorded the description of events leading up to admission and the doctor was advised to report the matter to the police, the out of hours team would liaise with the police hand over the case to their colleagues on Sunday morning. Since the paediatric consultant had considerable experience of child protection issues they did not feel uncomfortable with the course of action. This information was not recorded as a section 47 referral and the appropriate child protection paperwork and procedures were not initiated. The worker concerned told the individual management review author that in their view the situation was “more important than a S47” and potentially a criminal matter. This response indicates a worrying lack of understanding regarding child care legislation and statutory guidance, which is clear that where a local authority has reasonable cause to suspect that a child in their area is suffering or is likely to suffer significant harm they should:

Make or cause to be made, such enquiries as they consider necessary to enable them to decide whether they should take any action to safeguard and promote the child’s welfare (Children Act 1989 section 47).

Baby D clearly fell within this category and the case should have been clearly logged as a section 47 enquiry. It was not sufficient for the worker to simply pass it to the Sunday day time shift for follow up. No guidance was sought from a manager although, even if the worker had contacted the out of hours team manager, it is likely that the course of action would have remained the same, as they told the individual management review author that although section 47

enquiries should have been instigated by OOH1, the decision making at this point was between the doctor and the police. This indicates insufficient child protection knowledge by both the worker and their manager and reliance solely on police protection powers to safeguard children out of hours; an action which should only be taken if all other routes, such as an Emergency Protection Order, are unavailable.

4.25 In addition statutory guidance is clear that section 47 enquiries may run concurrently with police investigations (Working Together 2010 paragraph 5.60). It is not an “either/or” situation with the local authority and the police each having their clearly defined role. In this case the safety of the half sibling should also have been properly considered by the local authority rather than an assumption made that they were safe because they were with their mother.

4.26 The paediatric consultant next informed Thames Valley Police who said that they would inform their child protection unit. Police attended the ward soon afterwards, interviewed the parents and advised the medical staff that no relatives were to be left unsupervised with Baby D. The police officers were given a URN (Unique Reference Number) by the hospital in order to facilitate further information sharing.

4.27 On Sunday morning Mother informed the duty doctor that Father looked after his two year old child on Sunday and Wednesday and was due to pick them up that morning. The child would then be in the sole care of either Father or his mother. The hospital individual management review notes that this information was then relayed to Thames Valley Police.

4.28 At 9.45am Sunday morning the out of hours team (OOH worker 2) received a telephone call from Thames Valley Police. At this point the out of hours worker was unable to give the police any detailed information about other family members, including father’s older child, since the ICS and Swift IT systems were undergoing routine planned maintenance.

4.29 The police asked the out of hours worker to attend a strategy meeting at Hospital 2. The out of hours worker explained that this was not possible as they

were the only worker on shift and that the baby was in a safe place in hospital. Father's child by a previous relationship was thought to be safe as she lived with her Mother rather than Father. Again there is no indication that this case was logged as a child protection referral and correct procedures followed, including Social Care taking a lead role in ensuring that enquiries under section 47 Children Act 1989 were commenced and a plan put in place to promote the safety of *all* children who may have suffered or be at risk of significant harm. Whilst it was reasonable to wait until Sunday morning for a strategy discussion, it was not acceptable practice for the local authority to refuse to convene such a discussion and make sure that adequate plans were in place to protect both Baby D and their half sibling. This is not in line with local procedures which state:

Where both agencies have responsibilities with respect to a child, they must cooperate to ensure joint investigation (combining the parallel processes of a s.47enquiry and a criminal investigation) is undertaken in the best interests of the child. This should primarily be achieved through the co-ordination of activities at strategy discussions (BSCB procedures para 12.3).

4.30 The lack of strategy discussion and clearly documented plan left hospital staff vulnerable in the face of caring for a baby with severe injuries, possibly caused by family members who could at any time seek to remove the child from hospital.

4.31 There is no indication that any consideration was given by the out of hours worker to discussing the case with a manager or accessing legal advice which is available twenty four hours a day from an on call Buckinghamshire County Council lawyer. Instead OOH2 called a colleague who had experience in child protection work to discuss the most appropriate course of action. Should this incident have happened within normal working hours there would have been no question that there would have been access to supervision and detailed discussions with a manager regarding next steps.

4.32 Later on the Sunday morning there was a further telephone call between the out of hours worker and the police during which the police officer was informed that a strategy meeting would take place on the Monday morning. The police officer

was asked to obtain the parents' agreement that they would not visit the child unsupervised. The social care records note that the police put in place a "police protection order" as "back up". Thames Valley Police visited the ward later that morning (11.00am), had a meeting with the consultant paediatrician and said that the parents could have supervised access and a strategy meeting would be held with Social Care the next day.

4.33 Police records show that at 1.00pm police protection powers were used[5] with the intention of preventing Father or Paternal Grandmother having contact with his older daughter who was residing with her mother. At 3.00pm police protection powers were used once more in respect of Baby D preventing contact with Mother, Father and paternal grandparents until a strategy meeting could be held by Children's Social Care on Monday morning.

4.34 During Sunday afternoon the out of hours worker (OOH2) handed over to their colleague OOH3. Unusually this was a face to face handover as the out of hours team were operating from a council building rather than home due to the planned computer maintenance. OOH2 gave OOH3 a strategy form and expected them to contact the hospital, record actions on the form and send it off to the day time team ready for Monday morning.

4.35 Hospital records show that an out of hours social worker contacted the ward for information at 8.05pm. Since they had no URN number it was quite appropriate that information was not shared by the ward at this point. The out of hours worker called again with the URN number and hospital notes record that they wished to obtain information about parents' visiting rights. They were informed that Baby D had no visitors since 3pm and that parents were not allowed to visit until a strategy meeting was held. The hospital records at this point appear to indicate that the social worker was being informed of decisions and actions rather than coordinating the process in order to ensure the safety of all children, including Father's oldest child. There is no reference to this contact in the out of hours chronology.

[5] Section 46 Children Act 1989 allows a police officer, where they have reasonable cause to believe that a child would otherwise be likely to suffer significant harm, to" take reasonable steps to ensure that the child's removal from any hospital, or other place in which the child is then being accommodated is prevented". This is known as taking a child into police protection and lasts for 72 hours.

4.36 Out of hours records do show that OOH3 (the team manager working on shift) contacted the police at 9.36pm to confirm the parents' contact arrangements and confirm that a strategy meeting would be held on Monday. OOH3 e-mailed the next member coming on shift with an update on Baby D and asked them to e-mail the referral and assessment team before the start of the working day on Monday. This e-mail was not sent. 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, he was relatively new to the team and it was his first experience of computer systems being unavailable.

4.37 Thames Valley Police considered making an official complaint regarding the actions of the out of hours team. To date no complaint has been received and the serious case review panel has been informed that this was due to an expectation that the actions of the out of hours team would be explored during the serious case review.

5. ANALYSIS

5.1 This analysis of information received by the serious case review panel has been informed by the findings and recommendations of the individual management reviews. These reviews provide an important framework for improving practice in the individual organisations that had contact with the family and an evaluation of each one, as well as a summary of the learning that has been used to inform this overview, is contained within appendix one of this report.

5.2 The purpose of this overview report is to take an overarching look at the information from the individual reviews. Its aim to understand the whole picture, with an emphasis on understanding the underlying cause of any gaps in the services delivered and whether agencies could have worked better, collectively or individually, to prevent the abuse taking place.

Recognising and responding to domestic violence

5.3 It is clear from all the information submitted to this review that there was a failure to recognise and respond appropriately to the significance of the reported

assault on Mother during pregnancy. The role of health professionals in this regard is clearly summed up in the health overview report as follows:

All 3 health IMRs identify either a lack of recognition, or unawareness, of the potential significance of the reported assault on Mother at the beginning of June, or the most appropriate response. The GP recorded the incident and completed a medical assessment in relation to the health of the mother and unborn baby but took no further action to communicate with the community midwife, police or children's social care. Four weeks later the community midwife noted that there had been 'a stressful split from partner requiring a restraining order' but did not appear to recognise risks associated with this in light of the earlier GP entry regarding the reported assault. On Mother's attendance at the hospital with post coital bleeding, and accompanied by her partner, nine days later there was no connection made with the previous history documented in the HHR of the assault and the stressful split from partner. (para 5.2.4)

5.4 In addition:

The GP completed a thorough assessment of the physical health of the mother and her unborn baby and documented his findings in her GP clinical records and also wrote in her HHR 'alleged assault today. No trauma to abdomen'. Any further assessment was based on assumptions that, as the assault had been reported to the police, it was a police responsibility to establish the veracity of the incident and deal accordingly through police channels. A further assumption was made that Mother was not at further risk as she was living in her mother's house and the GP assumed that the relationship was finished. Consequently the GP did not feel it was necessary to discuss this disclosure with the practice lead for child protection or with the community midwife. (para 5.2.5)

5.5 The above actions indicate a lack of awareness of research into domestic violence, particularly in relation to risks during pregnancy and the likely increase in violence post separation.[6] The lack of knowledge within primary health care was confirmed to the panel by the GP individual management review author and the health overview report notes that "research evidence suggests that GPs do not have sufficient training on domestic abuse to enable them to understand the

[6] Humphreys, C. (2006) 'Relevant Evidence for Practice' in Humphreys, C and Stanley, N *Domestic Violence and Child Protection.* London. JKP

crucial role they could play in supporting victim of domestic violence .... Most GP surgeries do not include the response expected from clinicians to domestic violence in practice clinical guidelines or procedures". Interviews with midwifery staff also showed that they held the same belief as the GP that, as Mother had split from her partner at the point of the reported assault, the risk of further domestic violence was low. There is therefore an appropriate focus across the health recommendations on ensuring training is completed by all relevant staff and it will be important that Buckinghamshire Safeguarding Children Board evaluates the effectiveness of this training programme.

5.6 Supervision is often one tool which can help to "maintain a degree of objectivity and challenge fixed views, test and assess the evidence base for assessment and decisions" [7]. The overview author therefore questioned the effectiveness of the supervision arrangements within Health in challenging professionals to consider the significance of the information about potential domestic violence. Within Buckinghamshire considerable attention has been paid to developing supervision arrangements within health settings. For example, there has been a paper audit of supervision within community health, the findings of which were reported to the monitoring and evaluation sub group of Buckinghamshire Safeguarding Children Board. The report showed that there had been a considerable improvement in the regularity of supervision and quality of recording. This paper audit has now been followed by obtaining staff feedback which has revealed a high level of satisfaction with supervision arrangements. The same audit process has not been undertaken within the hospital trust but the panel were informed that regular safeguarding supervision is in place. It is the conclusion of the panel and the overview author that the issue here is that relevant information was not discussed with supervisors or child protection lead professionals due to the fundamental lack of understanding of the significance of domestic violence, rather than problems with the supervision system itself.

5.7 Thames Valley Police also played an important role in recognising and responding to the reported assault. They responded promptly to the initial allegation although the individual management review does highlight that the

[7] HMG (2010) *Working Together to Safeguard Children* paragraph 4.51.

investigation could have been more proactive in, for example, conducting house to house enquiries. The overview author and panel have also discussed the fact that the police did not contact the GP once they knew mother had been seen at the surgery following the assault. Whilst this may not have been thought to increase the evidence available in this case, it would have had the impact of ensuring that the GP was fully aware of the nature and limitations of police involvement in the case.

5.8 One key area of learning for Thames Valley Police was in relation to recognition of the unborn child as "involved" in situations of domestic violence and therefore recorded on the relevant system. This will ensure that the Child Abuse Investigation Unit are informed and facilitate multi professional working including notification to Children's Social Care who, where appropriate, can facilitate the provision of support services.

.

5.9 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".

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

5.10 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 more generally practice across health agencies did not prompt practitioners to undertake a holistic assessment of Mother's circumstances. For example, ante

natal records did not specify whether mother attended alone or with another person, the assumption that Maternal Grandmother was supportive was not fully explored and following Mother's attendance at the GP surgery with injuries there was no consideration given to ascertaining from Father's GP (at a different practice) whether there was any significant history that might have impacted on the safety of Mother and the unborn child. Indeed, 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.

5.11 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. For example, hospitals have a particular method for storing confidential information (in a "buff" folder) but GPs are unlikely to be aware of its existence or the information contained within it. Community midwives do have access to GP records when in the surgery but there will be a time delay in accessing these. A great reliance is placed during the ante natal phase on hand held records for sharing information, but there are limitations to the extent to which sensitive information may be recorded in these notes, and such a system does rely on all staff being aware of their professional responsibility to review previous entries. These records are not available to the health visitor as the record is retained in hospital, and handover from the community midwife to the health visitor was via leaving a telephone message; a practice which was described as "normal". The health visitor was therefore not aware of the assault on Mother during pregnancy.

5.12 A recent evaluation of serious case reviews by Ofsted[8] identified issues which are also features of this review, notably the need for better coordination between the different aspects of health provision involved in safeguarding babies, and the crucial role of GPs during the ante natal and post natal phases. The Ofsted evaluation noted that: "Local Safeguarding Children Boards should scrutinise local systems for transfer of cases between the midwifery service,

[8] Ofsted (October 2011) *Ages of concern: learning lessons from serious case reviews* Reference. 110080

the health visiting service and GPs". This has been picked up within this review in relation to the development of a structured framework for liaison between professionals (Buckinghamshire Healthcare NHS Trust Maternity and Health Visiting recommendation four). The need to promote more effective information sharing via primary health care meetings is also identified within the GP and the health overview recommendations.

5.13 It is clear that Thames Valley Police were unhappy about the quality of response from the out of hours service following the injury. This response is explored in more detail in the section below which identifies severe limitations in the response from the out of hours team which affected the quality of multidisciplinary working. 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.

The role of the out of hours service in child protection

5.14 The significance of the actions of the out of hours service lies in the degree to which Baby D was adequately safeguarded over the weekend and whether adequate consideration was given to the safety of other children within the family; namely Father's oldest child. The action taken by workers within the team has raised a number of concerns about practice which could have adversely impacted on the safety of both children.

5.15 The practice issues emerging from this review are:

- Failure to recognise the original referral from Hospital 2 as one that required action under Section 47.
- Lack of proper attention to the safety of Father's oldest child.
- Lack of a proactive approach by out of hours social workers in taking

responsibility for the case and organising a strategy discussion to develop a coherent agreed plan with the police and hospital.

- The perception of the out of hours worker that they should not attend a strategy meeting in case a Mental Health Act assessment or other emergency occurred.
- Access to management oversight and advice.
- Failure to pass details of the case to the team on Monday morning.

5.16 Underpinning these issues are a number of factors:

- The perceived role of an out of hours service both within the team, by partner agencies and the 'fit' between role and legislative requirements.
- Capacity issues within the team.
- The knowledge and skills of the staff in relation to child care work.
- Access to management support and advice.

5.17 One significant factor in this case is whether workers in the out of hours service see themselves as delivering an equivalent social work service to that provided in daytime, or whether their role is mainly to triage referrals, provide a first response in emergencies and hold situations until the day time teams were available. The papers provided to this review indicate that in relation to child care work the team veers towards the latter interpretation. Comments indicating that staff have never attended a strategy meeting and do not believe that they would get as far as section 47 enquiries and are not trained to apply for an Emergency Protection Order suggest that child care work is seen as a "holding" operation with a focus on making sure that the child is immediately safe. In this case such an approach resulted in a lack of focus on the bigger picture, including the safety of father's oldest child and a reliance on police protection as a first resort which is not in line with the spirit of the Children Act 1989. In addition there was a lack of coherent recorded planning, leaving hospital staff vulnerable should the parents have tried to remove Baby D.

5.18 As well as the immediate practice implications a focus on a "holding" approach to child care work out of hours means that the service may not always be able to comply with statutory guidance or local child protection procedures, which

require that the local authority takes the lead whenever a child has suffered or is likely to suffer significant harm. It is not acceptable that a child and family receive a substandard service because a child abuse incident has occurred over a weekend.

5.19 The understanding of the team regarding their role appears to fit with a comment in the risk assessment carried out prior to the restructuring of the service in April 2011. This notes in the weaknesses column:

"generic skill base is out of step with daytime service specialisation, although the brief to 'hold situations until daytime services can respond' mitigates this."

5.20 There is no evidence that the Local Safeguarding Children Board was consulted regarding the restructuring, nor was any consideration given to compliance with the Climbié recommendation regarding out of hours services, a recommendation accepted by the Government at the time and with which local authorities were expected to demonstrate compliance; namely:

"*The chief executive of each local authority with social services responsibilities must ensure that specialist services are available to respond to the needs of children and families 24 hours a day, seven days a week. The safeguarding of children should not be part of the responsibilities of general out-of-office-hours teams*. (Page 142)

5.21 The capacity of the team post review means that there is one worker on duty covering the whole range of referrals across the County. The team manager is also part of the rota. Even though on the Saturday night and Sunday morning there were no mental health assessments, the worker on duty clearly felt that it was too risky to leave their office and attend a strategy meeting as there was no one to back them up. This raises a number of issues:

- The priority that appears to be given to mental health work over child care.
- Apparent lack of consideration to the role that mobile phones can play, including office phones being diverted to a mobile.
- The lack of availability of technology to assist conference calling,

preferably with a video link.

5.22 A reluctance to respond could also have been linked to a lack of knowledge and confidence on the part of the worker. From the information given to the individual management review author by team members (see appendix 1) as well as practice evidence, it is apparent that there is a lack of knowledge within the team regarding child care legislation, procedure and practice. The training received on child care matters is less robust than mental health training, although this needs to be understood within the context of a service whose role is perceived by their own organisation as holding matters until day time teams can take over. Nonetheless it is not acceptable for workers covering weekend periods to have had no training in applying for Emergency Protection Orders and to lack confidence in such basic child protection processes as conducting section 47 enquiries and convening strategy meetings.

5.23 In addition to the above there appears to have been a culture within which even serious cases such as this are not deemed to require formal consultation. An additional issue is that although the team manager is deemed to be first port of call for the workers, they are sometimes the worker on shift. In fact the only child care decision that procedures dictate should be discussed with a manager is the accommodation of a child, due to the funding implications associated with a placement away from home. Out of hours workers interviewed for this review confirmed that they did not feel this case needed to be referred to a manager since they were clear of the steps necessary to secure the safety of the child (i.e. police protection). The choice of the social worker to consult a colleague rather than a manager would not have been acceptable within normal working hours, when in situations such as these where there are serious and potentially far reaching decisions to be made social workers would always expect to consult a supervisor. This should be the same out of hours.

5.24 However there is no formal duty rota for managers providing support for the out of hours service and, if workers are aware that they are trespassing into personal time they may be less likely to consult for fear of being unnecessarily intrusive. Additionally there is no immediate access to child care management expertise for child protection issues such as this.

5.25 The job profile for out of hours workers necessarily stresses the ability to "use initiative, the ability to spot and seize opportunities and to act without being told". There is no requirement to know when to consult. Munro (2011)[9] is clear that critical appraisal of practice is crucial in order to reduce error and, drawing on work with fire-fighters, police officers and pilots she notes that we need mechanisms to challenge the feelings of certitude that stem from our intuitive responses to situations confronting us. This is no less the case for experienced workers and it is important that those operating on their own, out of hours, know how to use consultation processes and that these are readily available.

6. LESSONS LEARNT

6.1 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. The lack of focus on the unborn child as a potential victim and a full evaluation of the number of risk factors when completing the DASH assessment was also a feature of practice within Thames Valley Police. Ensuring that up to date knowledge is embedded across the professional community is therefore imperative in order to improve future practice. This cannot be done though training alone and will need also to include ongoing evaluation of the impact of training on practice decisions.

6.2 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

[9] Munro, E (2011) *The Munro Review of Child Protection: Final Report. A Child Centred System* Paragraphs 6.23-30

partnership.

6.3 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 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.

6.4 The reliance on a medical model of care did ensure that high standards of health care were achieved for mother and baby throughout. However, the lack of a focus on the whole family meant that potential vulnerabilities were not explored, most particularly in relation to mother and father's relationship, as well as assuming that support systems were in place within the family. This focus on individuals rather than the whole picture also occurred following the serious injuries, when scant attention appears to have been paid by police and social care to possible risks to Father's oldest child.

6.5 The degree to which the out of hours service have the capacity to provide a comprehensive response in child care situations has been highlighted by this review. Capacity includes numbers of staff, management support as well as the required knowledge and skill base. The Safeguarding Children Board is already taking decisive action in this area and the need for all partner agencies to be clear about what the service should provide for children and families is a focus of an overview report recommendation.

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[10] 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.

8. OVERVIEW REPORT RECOMMENDATIONS

8.1 Buckinghamshire Safeguarding Children Board should ask the Chief Executive of Buckinghamshire County Council to confirm that:

1. The expectations of stakeholders in respect of the role and function of the out of hours service in their work with children and their families are clear.
2. The service meets those expectations
3. 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 "medium”.

8.3 Buckinghamshire Safeguarding Children Board should evaluate the

[10] 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 2nd edition.* London: The Stationary Office

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 encourage 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 need 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 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 Team Manager 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 within Maternity.

10.20 BHT will ensure a structured framework is developed for liaison between professionals.

10.21 Practitioners to consider how best to assess the role of partners/fathers and other significant family members when undertaking the 'booking history' and 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 HVs and Midwives should attend their regular Primary Health Care Team (PHCT) meetings.

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

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

GP IMR General recommendations:

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

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

10.28 Midwives and Health Visitors should be invited and enabled to attend every Surgery's Primary Health Care Team Meeting.

Thames Valley Police

10.29 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.

10.30 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'

10.31 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.

10.32 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.

1. GP

Scope of IMR

1.1 This individual management review covers GP involvement with Mother and Father both before and after the birth of Baby D.

Quality of Process

1.2 The review was carried out by a GP who had no clinical or management responsibility for any of the family members involved in this review. There was therefore an appropriate level of independence built into the process and the review benefited from an author who had current experience of the GP working context. The author did not have extensive experience of safeguarding over and above that gained from the GP role. However, the presence of a GP on the serious case review panel, and very constructive discussions between the author and the panel during the process, meant that key practice issues were explored.

1.3 Records for Mother and Father were reviewed and interviews carried out with all relevant GPs. A review of the records did not note anything significant in respect of Father, and even if his GP was aware that he was about to become a parent once more there would have been nothing in the records to cause any concern. It was therefore appropriate that the individual management view did not explore Father's medical history in any detail.

Learning

1.4 The review helpfully highlights from a GP's perspective that medical care during the pregnancy was of good quality, and the process at Mother's surgery involved GPs playing a greater role in care during the ante natal period than is common in other practices, where it is more midwife-led. The problem with this approach is that there is less continuity of care than in a midwife-led approach and the author therefore makes a recommendation that the surgery should review the way in which it provides its ante natal services.

1.5 The most significant episode within this individual management review is the

presentation by Mother at the GP surgery following the reported assault by Father when she was pregnant. This is fully explored by the individual management review author from their own perspective as a GP and analysed against what might be expected practice. Whilst the author does not feel that the GP acted inappropriately in documenting the injuries and assuming the police would be dealing with the assault, it is noted that discussion with the wider team, including health visitors and midwives, would have been beneficial. The lack of communication between GP and health visitor after the birth of Baby D, particularly at the point where there were concerns about weight, is also highlighted, as is the issue of lack of attendance at practice meetings by health visitors and midwives. The need for this to be facilitated is within the report's recommendations.

1.6 One important issue that is not fully explored within the individual management review is that the GP felt that Mother was safe since she had separated from Father. This highlights a lack of awareness by the GP regarding current knowledge regarding risk factors and domestic violence which shows that women are at increased risk at the point of separation. This is picked up within the health overview and the main body of this report.

1.7 The fact that the post coital bleed (in a letter from the hospital to the GP) was not identified as indicative of a resumption of the relationship with father is not explored in detail within the individual management review but is explored fully within the health overview report.

Recommendations and action plan

1.8 The recommendations are divided between those specifically directed at the practice concerned and those which relate to practice across the Buckinghamshire area. These recommendations address the key learning points in relation to an understanding of domestic violence and communication within the health environment.

1.9 There is a comprehensive action plan with evidence that learning has already

been disseminated within the GP surgery and action has been taken to implement other recommendations.

2. Community Health

Scope of IMR

2.1 This individual management review covers the involvement of community midwifery and health visiting services with Mother, Father and Baby D.

Quality of Process

2.2 The individual management review was carried out by the lead professional for safeguarding on behalf of the Buckinghamshire Healthcare NHS Trust. The author was independent of any clinical, managerial or supervisory involvement of the care provided to Baby D or his mother. There is therefore an appropriate level of expertise and independence built into the process.

2.3 All relevant records were reviewed, including the “hand held records”, and interviews took place with key professionals who recalled providing care to Mother and Baby D.

2.4 Discussions also took place with staff who may not have had direct contact with the family but worked in an area of practice relevant to this review, such as the Day Assessment Unit at Hospital 1and the Ante and Postnatal ward. These discussions helped the individual management review author to gain an understanding of the skills, knowledge and experience of staff in those areas as well as processes and expected practice.

Learning

2.5 The report sets out in detail the contact that Mother had with midwives and the health visitor. There is also clarification of expected practice in important aspects of healthcare such as home visits, recording and conversations with mothers regarding risk factors such as domestic violence. The review identifies where practice fell short of expectations, although *why* this was the case in this particular instance is less clear.

2.6 One key issue is that of the routine enquiry into whether domestic violence is present. In this case there is no evidence of the enquiry taking place and the author has therefore made certain that immediate action was taken to ensure all staff had an awareness of their responsibility regarding such enquiries, and of the need to document whether the conversation has occurred and its outcome.

2.7 The report records that there are a number of missed opportunities to ensure a full risk assessment in relation to domestic abuse. However, it importantly also indicates that lack of enquiry is not confined to this case, that midwives may find the process problematic due to such factors as fear of taking the lid off something that will get out of control, fear of not knowing what to do next, fear of causing offence, belief that this is not the province of the NHS and personal identification with the abuse either as victim or perpetrator. The review helpfully identifies that the current records may exacerbate the problem, with the pregnancy notes not including a space to record that routine enquiry has taken place. A recommendation specifies that the current training will need to be reviewed in order to ensure that it adequately covers how to ask routine questions relating to domestic violence.

2.8 The significant issue of lack of assessment of the reported assault at a time when Mother and Father were separating, and the linking of this information with the “post coital bleed”, is referred to within the review. The problem is identified as located within the failure to review the hand held records as well as an over-reliance on written communication between the GP and community midwife rather than face to face discussions.

2.9 The report helpfully points out that use of language within the hand held records is important, with the term “alleged assault” possibly conveying to Mother that her account could be doubted. The term “reported assault” may be more helpful.

2.10 The failure to consider the role of Father is identified within the report, although why this is the case is not analysed in any detail.

Recommendations and action plan

2.11 There are five recommendations addressing the key learning points within the individual management review. Three of the recommendations rely heavily on training to improve practice. It will be important to ensure that the impact of this training is evaluated.

2.12 The action plan shows progress with implementing learning. Updated Domestic Abuse guidelines are in place and the current domestic abuse training package having being reviewed.

3. Hospital

Scope of IMR

3.1 This individual management review considers all the hospital-based care provided by Buckinghamshire NHS Trust, both before and after the birth of Baby D.

Quality of process

3.2 The review was carried out by one of the named doctors for child protection within Buckinghamshire who had not had any clinical, managerial or supervisory involvement in the care provided to any member of the family. There was therefore an appropriate degree of experience and independence built into the review process.

3.3 All relevant medical records were reviewed and interviews carried out with key medical personnel.

Learning

3.4 The report gives a detailed account of the medical care provided to Mother and Baby D and identified clearly relevant practice issues including good practice, such as not giving out personal information to the out of hours social worker without the relevant identification code being given.

3.5 Medical care throughout is noted to be good but a theme identified consistently within the report is the lack of social history recorded within the files. There is no indication that this was taken verbally and not recorded, and the impression is of a lack of awareness by staff within the hospital regarding social context. This was particularly significant when Mother presented at hospital with a post coital bleed. The report does bring to the reader's attention that at this point the hand held records were not reviewed sufficiently thoroughly by either the midwife responsible for triage or the obstetrician in order to identify the history of presenting at the GP with symptoms consistent with the alleged assault by Father.

3.6 The general absence of a focus on male partners within the hospital is identified by the review with records lacking consistency in whether their presence was noted at all or, if it was, who they were.

3.7 The good medical practice, including the taking of a full social history at the point of the serious injuries is noted within the report. The importance of an experienced doctor leading the work within the hospital is referred to and it is inferred (rather than being explicitly stated) that it was because of the Consultant's experience that the lack of immediate intervention by Social Care was not questioned. The consultant felt confident in managing the case with the police until such time as social workers could get involved. The report does not explore whether or not the consultant *should* have been more proactive in challenging the response of Social Care in order to ensure all the appropriate safeguards were in place.

Recommendations and action plan

3.8 The lack of social history is addressed by a recommendation linked to an action focused on ensuring that admission records prompt questions about social history and that triage staff pass this onto the relevant doctor.

4. Thames Valley Police

Scope of IMR

4.1 This review covers in detail the contact that Thames Valley Police have had with Baby D, Mother and Father in the timeframe specified within the terms of reference. In addition the review author conducted background checks on the wider family network in order to ensure that all relevant information was available to the serious case review process.

Quality of process

4.2 The review was completed by a police officer who had no involvement with this case and is one of a team set up to deal with all individual management review requests relating to vulnerable people. The team are all experienced detectives with background in investigating crimes relating to vulnerable people, and there is therefore an appropriate level of experience and independence built into the individual management review process.

4.3 The review included a full review of all relevant records and interviewed six police officers who had involvement with Baby D and his family. The author analysis was enhanced by their discussions with nine members of Thames Valley Police force with expertise in relevant areas, including police training, database and child abuse investigations. Information was also obtained from a CPS senior prosecutor.

4.4 The analysis of events post injury was limited by the direction of the Senior Investigating Officer to set out the facts rather than explore the quality of practice and interactions with other professionals and family members. This is problematic since Thames Valley Police were relying on the serious case review to explore quality of practice post injury in lieu of them making an official compliant to Adult Services. However at the request of the serious case review panel additional information was supplied by the individual management review author and provided sufficient information for the overview report. Thames Valley Police may wish to analyse for their own benefit how best to escalate concerns where there are concerns about practice in another organisation.

Learning

4.5 This was a very thorough review and the report was very helpful in assisting the serious case review process as well as providing a critical review of the actions of Thames Valley Police in order to inform learning and practice development within the organisation.

4.6 The review explores the quality of response in a situation of alleged domestic violence particularly where the alleged victim does not want to press charges. The report highlights positive features of the police officers' actions (such as taking photographs of the injuries) as well as lessons for future practice. Lessons include the need to ensure that the TVP "positive intervention policy is implemented ensuring the decision whether or not to arrest clearly lies with the police officer rather than the alleged victim as well as the need to consider the possibility of house to house enquiries". The latter learning point has already been circulated to all officers in a recent *Learning points from the Domestic Abuse Panel* bulletin.

4.7 The report highlights where the required procedure (obtaining supervisory quality assurance review) had not been followed following completion of the DASH assessment and helpfully identifies where the checks within the system rectified this error the next morning.

4.8 The need to understand that safeguarding in situations of domestic violence extends to unborn children is clearly identified as a learning point and linked to lessons from another recent serious case review. In respect of unborn Baby D the review identifies that:

1. They were not identified as being "involved" in the incident due to their unborn status and the Child Abuse Investigation Unit was therefore not informed.
2. The current databases do not facilitate the recording of an unborn child as belonging to the same household as other "involved" parties, with an automatic notification being generated to Children's Social Care. It is positive that the new database system currently under development will

ensure that unborn children are given the same status as babies and children post birth.

Recommendations and action plan

4.9 There are four recommendations addressing the key issues of ensuring that unborn babies are identified as children for the purposes of safeguarding, particularly in situations of domestic violence. The need to ensure effective management oversight is also addressed.

4.10 The action plan shows evidence of progress with all recommendations. However the absence of intended outcomes means that there is no baseline for measuring impact on practice.

5. Buckinghamshire County Council: Adult Social Care

Scope of IMR

5.1 This individual management review primarily focuses on the intervention of the Buckinghamshire County Council out of hours service following the serious injury to Baby D. The individual management review author also interrogated all relevant records in order to ascertain whether there was any background information in respect of Mother or Father known to the County Council. The only information that came to light was one previous contact with Father when he was younger which had been recorded by Children and Young People's Services. A referral was made by Father's school after he alleged that his father had hit him with a hat. Father was recorded as having a degree of learning disability and some behaviour problems. There is no record of any action being taken by Children's Services and there is therefore no further reference to historical information within the individual management review.

Quality of process

5.2 The individual management review was completed by a senior manager within Adult Services who has a non-operational role within the Commissioning and Service Improvement Team. He had no previous knowledge or management

responsibility for work with Baby D, and an appropriate degree of independence was therefore built into the review process.

5.3 The search of relevant records in order to complete the chronology was thorough and interviews were initially held with the team leader and staff who were on duty during the period of Baby D's admission to hospital. Further information was sought from the team manager in response to the serious case review panel's request for clarification. In addition, the out of hours team were surveyed by the individual management review author following discussions with the serious case review panel. This survey obtained further information in respect of staff knowledge and confidence in dealing with child protection issues.

5.4 In order to ensure that the individual management review was informed by up to date child care knowledge and experience, the author also consulted with an operational manager within Children's Social Care.

Learning

5.5 The thoroughness of the process outlined above meant that every attempt was made to understand what happened, measure this against expected standards and also explore *why* practice did not always provide a quality service.

5.6 The report clearly identifies the lack of a proactive response by the out of hours team over the weekend and the failure to work within child protection procedures. Of particular concern is the failure to work jointly with the police and take responsibility for initiating and leading section 47 enquiries. One key issue that emerged is the lack of formal management support and advice from managers with child care knowledge and experience.

5.7 The issue of the knowledge and experience of the team in relation to child care is thoroughly explored. The challenges of needing to be expert in all aspects of social work practice is highlighted, as is the fact that staff generally receive less training for the child care aspects of their role than they do for mental health act assessments. There is no practical experience within the team of attending

strategy meetings, they are not trained in applying for an Emergency Protection Order and one member of staff is quoted as saying that due to the complexity of child care work, the legal knowledge required and the enormity of the decisions taken it is relatively more difficult to add this expertise and knowledge to existing skill sets. Lack of knowledge and confidence is demonstrated by one worker saying that “In the OOH team we would not reach the Section 47 stage”.

5.8 The impact of the non-availability of information systems due to planned improvement work carried out by ICT over the weekend is an important issue which is fully explored. Although the out of hours team had sought to mitigate the risks by working from on office base and making use of the detailed contact sheet recording system for all referrals, there was still a major impact on their capacity to respond to queries from the police in relation to family members.

5.9 The failure to hand over the case to the day time team on Monday morning was clearly an error and meant that the duty worker was not aware of the case when the police called regarding the strategy meeting. The staff member concerned cannot identify why the handover did not take place, although they do recall having to go out on a mental health assessment and it was their first experience of computer systems being unavailable.

5.10 The report notes information from the out of hours team manager that in each of the past two years the team has dealt with some 2,600 referrals on child care/child protection issues without serious incident and this demonstrates that child care knowledge is up to date and functioning well. This view is not analysed in any detail but the challenges of maintaining expertise across all aspects of practice is identified as a potential contributory factor within this review. One recommendation therefore relates to increasing the knowledge of the team through training on child care legislation.

5.11 Capacity issues linked to the staffing review implemented in April 2011 are fully explored within the report as well as the lack of clarity from partner agencies regarding the expectations of the service that should be provided out of hours.

The report comments on the lack of consultation with partners through the Local Safeguarding Children Board regarding the review and the lack of consideration as to whether the service is Climbié compliant. The impact of the reduction in staff numbers is noted, and the time consuming nature of mental health act assessments. The report does not, however, fully analyse the fact that there were no mental health assessments on Saturday night or Sunday morning and it appears to be the fear that one *might* be required that prevented attendance at the strategy meeting.

Recommendations and action plan

5.12 There are sixteen recommendations covering all the identified learning in the case and addressing practice, policy and organisational issues. They are linked to a comprehensive action plan. This is a challenging work programme which will need to dovetail with the action associated with overview report recommendation.

6. Health Overview

Scope

6.1 This report is an evaluation of the practice of all health professionals focusing on how all health organisations have interacted together. It has been prepared to inform the commissioners of health services in the Buckinghamshire area and has been completed in line with the requirements of Working Together to Safeguard Children.[11]

Quality of process

6.2 As required by national guidance the report was prepared by the designated nurse for child protection and is a thorough review of the health individual management reviews. The author attended meetings of the serious case review panel and was able to integrate into the report issues that emerged from discussion with the individual management review authors. In addition, informal discussions were held with individual management review authors and as a result the final report represents a comprehensive overview and analysis of

[11] HMG (2010) *Working Together to Safeguard Children.* Chapter 8 paragraph 8.30

health involvement with the family.

Learning

6.3 The report provides a comprehensive analysis of practice with a particular focus on ante natal assessments, the response to the reported domestic abuse incident and communication across the health community.

6.4 The need to ensure that staff feel confident in both asking questions about domestic abuse as part of the assessment process and identifying when there may be a need to take a proactive approach in relation to safeguarding children is explored fully within the report. The link between identification of potential harm and effective information sharing is clear, including the limitation of relying solely on written records as a means of communication.

6.5 A clear message is the need to ensure that there is a move from a reliance on a solely medical model during ante natal and post natal care to a situation where all health staff are confident in ensuring that the impact of social factors on the wellbeing of the child are assessed.

6.6 The report picks up on the notion identified with the GP individual management review on the potential for practice meetings to facilitate communication between GPs, midwives and health visitors. Currently these meetings primarily focus on elderly patients and end of life care and may not be seen as relevant to those working with babies and children. The need to find ways of adjusting this position and exploit the potential for more effective communication is helpfully considered and linked to a recommendation.

Recommendations and action plan

6.7 There are three relevant recommendations focusing on the work that can be undertaken by Commissioners to support practice improvements. These are linked to an action plan.