

Cambridgeshire Local Safeguarding Children Board

Executive Summary of the Serious Case Review of Baby A, Died 2006

December 10th 2009

1. INTRODUCTION:

- 1.1 Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards (LSCBs) to undertake Serious Case Reviews (SCR) in accordance with procedures set out in chapter 8 of 'Working Together to Safeguard Children' (HM Gov, 2006).
- 1.2 This SCR was commissioned because of the death of Baby A. at 7 weeks old, from a wide range of non-accidental injuries. The terms of reference were, in summary, to consider the services to the family before A.'s death and determine whether her death was in any way preventable, and to consider how services responded to the fatal injuries received by A.
- 1.3 The executive summary has been produced by the Serious Case Review Panel after considering the findings, conclusions and recommendations made by the Independent SCR Author. The recommendations in the overview report are accepted by the LSCB and reproduced in summary form here.
- 1.4 **Circumstances of Baby A.'s death.** A.'s father was found guilty of her murder. The mother was found not guilty of murder and causing death but pleaded guilty to allowing the death. Baby A. had severe multiple injuries including brain damage and died twelve days after her admission to hospital.
- 1.5 **Arrangements made for the Serious Case Review.** A SCR by the Local Safeguarding Children Board (LSCB) was formally commenced in March 2007. The overview report was delayed due to the re-scheduling and recommencement of criminal proceedings. Permission to undertake a 'refreshed SCR' in the light of the delay was given by the Government Office for the East in April 2009, although learning arising from the original Individual Management Reports (IMR's) was addressed in the interim period.
- 1.6 **Summary Agency and Family Involvement.** There were a number of services involved who have each conducted their own IMRs. Baby A.'s grandparents contributed to this review at the conclusion of the criminal trial. Baby A's mother decided not to contribute and Baby A's father did not respond to requests to participate.

2.0 LESSONS LEARNED ABOUT THE PERIOD BEFORE THE INJURIES

- 2.1 **Was there information which could have predicted violence, and if all the information had been put together would it have made a difference?** Within A.'s family unit there were a number of factors which may well have created stress, but which in themselves do not predict catastrophic violence to a child. **In addition**, domestic abuse only emerged as an issue during court hearings and was unknown to anyone outside the parents until long after A.'s death.
- 2.2 It was the conclusion of the SCR that the information known at the period before the injuries took place would not have reached the threshold for Social Care intervention as there was no indication of any risk to a child.
- 2.3 If all the issues affecting the family had been pulled together in one place and considered all at once this would have identified that there were some vulnerabilities, but that did not lead the SCR to conclude that the death could have been prevented.

- 2.4 The parents were known to law enforcement agencies, but this involvement was not known by community nurses and midwives. The SCR concluded that it would have been unrealistic, without any additional knowledge of child risk, for those agencies to have made a referral.
- 2.5 **What can be learned from communications between organisations and professionals?** The SCR conclude that whilst there were a number of issues relating to the nature and quality of communication there are no grounds to assume that better communication would have saved Baby A.
- 2.6 **SCR recommendations on those issues identified arising from the period before A.'s injuries.** This section summarises the main recommendations from the Overview Report of the SCR as they relate to issues about what happened before Baby A. was killed. The recommendations have all been accepted by the LSCB and the organisations concerned. The overarching need is for the development of a framework for sharing information about individuals which is, in isolation, well beneath the threshold that would raise concerns about the potential for serious harm to themselves or others, but which, if put together, might indicate significant vulnerability.

Learning point	Summary Recommendations
Referral Procedures	<ul style="list-style-type: none"> • The planned Police review of when and how to refer cases to Children and Young People's Services must include the ability to make a judgement that there <i>might</i> be a concern and not just when there is a known concern. • The UK Border Agency's safeguarding guidance should include advice on what to refer on if one partner's immigration status may have an impact on the parenting of a vulnerable partner. • When General Practices refer mothers to maternity services, they must examine the history to see if there was any recent or previous post-natal depression.
Recording and Record Checks	<ul style="list-style-type: none"> • If a mother attending a GP Practice appears low in mood the mother's medical records should be checked. • All agencies should reinforce the need for proper recording of ethnicity and for consideration of associated cultural issues.
Information sharing	<ul style="list-style-type: none"> • NHS Trusts and Primary Care Trusts in Cambridgeshire should work with GPs and primary care teams to develop local guidance on what information should be passed between team members, including community midwives, where there is no obvious concern but a potential for some risk. • The GP Practice involved is asked to review the way information is shared between GPs and with community colleagues to ensure each discipline knows what it needs to know to be

	effective.
Discharging Cases	<ul style="list-style-type: none"> The practice of midwives [NHS Trust 1] discharging mothers and babies over the phone should be reviewed and criteria set for when it is not appropriate.

3.0 LESSONS LEARNED AFTER THE INJURIES

- 3.1 **Setting the scene.** The issues identified in this section are about whether the response of services to the injuries to Baby A. was appropriate, the action taken to protect the children was appropriate, and the injuries diagnosed as early as possible.
- 3.2 **Was the response to and the diagnosis of the injuries appropriate?** The ambulance service and the GP attended the home promptly when the mother called 999 after Baby A.'s collapse. Everything possible was done to revive her, and every effort was made to preserve her life, but it proved impossible. Twelve days later life support was discontinued with the parents agreement and agreement reached in advance with Children and Young People's Services (CYPS) as Baby A. was then subject to an interim care order.
- 3.3 The evidence received by the SCR is that staff at both hospitals and social work staff worked hard and well to support the parents and keep them informed. Appropriate safeguarding meetings were held by the police and CYPS, and necessary protection orders obtained on Baby A. and their older sibling as soon as None Accidental Injuries (NAI) were identified. Evidence was collected appropriately by the police. The SCR has identified concerns about the speed of diagnosis of Baby A.'s injuries, and related communication, and a small number of procedural issues (none of which impacted on the safety of the child/ren).
- 3.4 The SCR Panel feel that it is quite appropriate that first priority be given to immediate life-saving action, but when non-mobile babies collapse there must always be a holistic approach to diagnosis, and after immediate stabilisation such babies must have a full physical examination.
- 3.5 Some of the injuries eventually found on Baby A. were unusual and not easy to diagnose in terms of causation. Some were not discovered, or diagnosed fully, until the post mortem.
- 3.6 There was a delay in CYPS obtaining a child protection medical on the older sibling after the NAI to Baby A. was identified. It is necessary to emphasise strongly the need for speedy child protection medicals of siblings.
- 3.7 **Actions and other process/quality issues.** There are some lessons to be learned, and actions identified by agencies arising from these post injury issues.
- 3.8 **Record keeping:** This was poor in many parts of the system, notably those records of discussions with staff in other organisations, handover paperwork, clarity around the source of information and whether it was evidenced.

3.9 **SCR recommendations on issues after the injuries to Baby A.** This section summarises the main recommendations from the Overview Report of the SCR, as they relate to issues about what happened after Baby A. was injured. The overarching issue is the need to take a holistic view about the diagnosis of very ill children, and the need to actively consider all possibilities.

Medical Examinations	<ul style="list-style-type: none"> • Acute NHS Trusts: All children should have a complete physical examination after admission to Intensive Care and following stabilisation. Trusts 1, 2 and 3 are recommended to review again through their own clinical governance arrangements what can be learned from the omissions in practice relating to A.'s leg, with the LSCB coordinating the spread of any learned lessons. • Trusts 1 and 3 should consider again the delays in diagnosis of the other injuries. • Police and CYPS: When a child is suspected of being deliberately hurt, any siblings must have child protection medicals without delay.
Record Keeping	<ul style="list-style-type: none"> • All Agencies: The importance of accurate and consistent record keeping must be re-emphasised to all professional staff, especially hand over information and the contents of discussion with staff in other services or hospitals. • CYPS should ensure that strategy meetings are minuted as per LSCB guidance.
Case Management	<ul style="list-style-type: none"> • Acute NHS Trusts: All hospitals should ensure there are systems in place to obtain speedy specialist advice, regardless of holiday periods. • CYPS should consider splitting the responsibility for the investigation around one child and the looked after duties for the sibling.

CONCLUSION

- 4.0 This review has identified a number of key learning points for Cambridgeshire. These are: the approach to information sharing, missed opportunities to share information, risk assessment practice, taking a holistic approach to diagnosis of illness/injury, and recording.
- 5.0 It has also identified a range of policy issues. These issues will be shared with the appropriate regional and national bodies. Given the fact that the review applies to services that are also provided by the Police and the NHS in Peterborough the LSCB have agreed to share the full overview report with Peterborough LSCB.
- 5.1 The parents were subject to numerous pressures and stresses. In hindsight, when these are all identified and considered together, the panel can understand it might look as if public services could have intervened or at least made inquiries about the family. In reality there was little to alert staff to the potential of violence to a baby. Any known social pressures were countered by a view that the mother was well supported with healthy babies. The fact that some staff were not told about information that would have changed their risk assessment is regrettable, but would

probably have made little difference given the family way of keeping really important issues of risk away from public sector professional staff. The true state of the parental relationship only began to emerge over a year after A.'s death.

- 5.2 Even if all the risk factors were known to one agency prior to the injuries, there would have been no grounds for formal intervention, or probably even for an assessment by social care. It is hoped the learning from this case will allow a debate, particularly about what information should be shared amongst professional staff when there are pressures but no obvious risk of harm. This will inform future dealings with vulnerable families under pressure.
- 5.3 The response of services was prompt, intense and caring. The skilled and emotive work of clinical staff in dealing with such a sad case with emerging criminal overtones must be recognised, despite the comments above about some issues with communications and diagnosis. The same applies to social work staff. Procedural and organisational issues identified in this SCR did not harm either child, but the lessons learned from these issues will no doubt benefit families in the future.

Jane Held
Independent Chair of Serious Case Review Panel
10.12.09