torbaysafeguarding childrenboard

# Torbay **Safeguarding Children** Board

## Serious Case Review

## C40 - a child who died aged 4 weeks

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Keeping children safe is everyone's responsibility

Torbay Council Children's Services ■ Police ■ Health ■ Careers South West
Youth Offending Team ■ Probation ■ CAFCASS
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www.torbay.gov.uk/tscb

## 1 Introduction

1.1 A four-week-old baby was found unresponsive at home by his mother and later declared dead in hospital. A post mortem examination carried out three days later showed that the baby had suffered serious head injuries that had led to the death. There was no explanation offered for these injuries and they were considered to have been non-accidental. A police investigation resulted in the arrest and subsequent conviction of the father for manslaughter.

1.2 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely:

1.3 5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.

1.4 (2) For the purposes of paragraph (1) (e) a serious case is one where:

> abuse or neglect of a child is known or suspected; and
>
> either - (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.5 Once it became clear that the fatal injuries to the child were non-accidental a decision was made that a Serious Case Review (SCR) should be undertaken. The child was resident in Torbay at the time of death therefore Torbay LSCB took responsibility for the completion of the SCR. However it was recognised that the mother had been resident in Devon during her pregnancy and therefore the LSCB there also needed to be involved with the review.

1.6 A Serious Case Review Panel was established and Chaired by Bob Spencer, who was at the time of the start of the review, the Independent Chair of Torbay Local Safeguarding Children Board (TSCB). The Panel was initially made up of the Business Manager of TSCB who represented Torbay Children’s Services, Detective Chief Inspector, Devon and Cornwall Police and the Designated Doctor for Torbay. An independent consultant was commissioned by Devon Children’s Services to complete a chronology.

1.7 The purpose of Serious Case Reviews is to:

- establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and
- as a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

1.8 Working Together 2010[1] provided detailed guidance about the purpose and processes of Serious Case Reviews and this SCR was initially structured in line with this guidance. Organisations that had been involved with provision of services to the child and family were asked to compile a chronology of their involvement. The individual chronologies were submitted to the LSCB and integrated into a single multiagency chronology.

1.9 Members of the SCR sub-group and SCR Panel gave lengthy consideration to the methodology and scope of the review. It was recognised that a number of reviews had been undertaken in the recent past within Torbay in respect of the deaths of very young children and that learning from these deaths was still subject to action plans to embed the learning into practice. In addition there had been minimal multiagency involvement in the family prior to the death of this child. It was considered that repetition of a similar type of review would neither be the best way to learn lessons from the circumstance of this death nor the best use of resources. The revised edition of Working Together[2] published in March 2013 is less prescriptive about the way that SCRs are conducted as long as the methodology:

- r*ecognises the complex circumstances in which professionals work together to safeguard children;*
- *seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;*
- *seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;*
- *is transparent about the way data is collected and analysed; and*
- *makes use of relevant research and case evidence to inform the findings*

Working Together to Safeguard Children (2013) p67

1.10 The LSCB had previously undertaken a review using the SCIE Learning Together Systems Methodology and judged that it would be beneficial to undertake this review using, at least in part, this framework.

1.11 The SCR panel therefore decided that Individual Management Reviews would not be sought from individual agencies, but that a different approach would be used to review agency involvement with the family. It was agreed that there should be three strands to the review. A Health Overview Report that considered the involvement with the family of all health professionals would be submitted with information gathered and analysed using the Social Care

[1] HM Government (2010) *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children*

[2] HM Government (2013) *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children, www.education.gov.uk/aboutdfe/statutory Reference: DFE-00030-2013*

Institute for Excellence (SCIE) Learning Together Systems Methodology[3]. This review did not include contacts with the family in the two days before the child's death due to the possibility of health practitioners being required to provide evidence to the criminal proceedings.

1.12 The actions that took place immediately after the death of the child that linked to the Child Death Review process were addressed separately from the Health Overview using some of the techniques developed as part of the SCIE methodology. This involved having 'conversations' with the practitioners involved in the Strategy meeting, a Coroner's Officer and the Service Manager for the Peninsula Child Death Review.

1.13 Devon Children's Services were asked to consider their involvement with the child and family using an appropriate methodology. There was significant delay in the receipt by the SCR panel of this contribution to the review in spite of regular requests by the SCR Panel Chair and offers of support from Panel members. This delay impacted on the timeliness of the overall review process.

1.14 An independent consultant was commissioned to write an overview report. The overview author is a qualified nurse and health visitor with more than twenty years experience working within the NHS as a specialist in safeguarding children as both a named and designated nurse. As an independent consultant the author has experience as a member of a number of Serious Case Review Panels and has written both Overview Reports and Individual Management Reviews, for a number of LSCBs in England and Wales.

1.15 Specific areas for review

- To consider if there were any identifiable critical predictors of the event in the parents' background, history and functioning that practitioners could have recognised in their involvement with family members.
- To examine practitioners' understanding and use of thresholds for referrals and access to services.
- To consider the quality and effectiveness of assessments of the parents ability to care for and protect their children.
- To examine the effectiveness of the Child Death Overview process to consider and respond appropriately to safeguarding issues of surviving siblings.

1.16 The health overview was undertaken by a review team made up of the Designated Doctor, the Named Nurse for community services, the Named Midwife from the hospital trust and an independent practitioner with Primary Care experience. It considered input to the family provided by General Practitioners in both Devon and Torbay, maternity services provided by South Devon Healthcare NHS Foundation Trust, health visiting services provided by

[3] Social Care Institute for Excellence (2008) *Learning Together to safeguard children: developing a multi-agency systems approach for case reviews*

Torbay and Southern Devon Health and Care NHS Trust and NHS Devon[4] and the Perinatal Mental Health Service provided by Devon Partnership NHS Trust.

1.17 The review of issues relating to the Child Death Overview Process was undertaken by the Overview Author and the LSCB Business Manager.

1.18 An independent consultant was commissioned by Devon Children's Services to undertake the review of interventions with the family by Children's Services in Devon.

1.19 The panel ascertained that C40's sibling was fully safeguarded and subject to care proceedings. The proceedings resulted in Torbay Council being granted a Supervision Order. At the time of the report the child is living with his mother in independent supported accommodation.

## 2 The Serious Case Review Process

2.1 The SCR was overseen by a Panel chaired by an independent consultant with experience as an independent LSCB Chair and of chairing other Serious Case Review Panels. The Panel comprised representatives from the Police, Torbay Children's Services, Devon Children Services, health service commissioners and providers and Torbay LSCB. Torbay LSCB provided administrative support. The Overview Report author also attended the Panel meetings. The health service representation comprised the Review Team for the health overview and a representative from South Western Ambulance Trust.

2.2 The Panel met at strategic points in the process to define Terms of Reference for the Review, to review the inter-agency chronology, to receive the Health Overview report and the Overview Report. The Panel met on a total of eight occasions. A final draft of the overview report was completed in November 2013, although this did not include information from Devon Children's Services. The final report was completed after completion of the criminal process to enable input from the family. This report incorporated information presented in the delayed review of the involvement of Devon Children's Services. The final overview report was presented to the Torbay LSCB Executive in July 2014.

2.3 The health overview was undertaken using the SCIE methodology. The review team identified practitioners who were key to the services provided for the family (the Case Group) and, having briefed them about the structure and purpose of the review, each practitioner was engaged in a structured 'conversation'[5] with two of the review team. In total the review team held conversations with 11 practitioners from health visiting (two), midwifery (four), perinatal mental health (one), General Practice (four) who had been involved with the family across two addresses. The purpose of the conversations was to

[4] Provided by Devon Integrated Care Services since March 2013

[5] The SCIE methodology refers to conversations to avoid the connotation of formal fact-finding endeavours. They are used to build a picture of how things looked to practitioners at the time that they were involved, the practitioners are asked to provide a narrative account of their involvement, to identify key practice episodes and contributory factors that influenced the way the case developed and why they acted as they did.

gain an understanding of the practitioners' contact with the family and to learn how people saw things at the time and explore with them what was influencing their work at the time. Practitioners were asked to review their professional records prior to and had access to them during the conversations.

2.4 The review team used data from the conversations to develop a narrative of health intervention with the family. This was shared with the Case Group in two meetings to ensure accuracy and context.

2.5 The review team then analysed the content of the conversations taking account of relevant policies, procedural and strategic documents. The team developed a report of their analysis which was discussed at two meetings with the Case Group at the end of the fieldwork period and when a draft report had been written. The purpose of these meetings was to discuss the process and the key messages and findings that were coming out of the health review. Some additional safeguarding staff, managers and LSCB representative were also present for the second meeting.

2.6 The SCR Overview Report writer and the LSCB Business Manager considered issues that related to the actions taken immediately after the death of the child and the processes associated with the Child Death Overview practices in a separate piece of work. Conversations were held with professionals who had been present at a Strategy Meeting that was held the day after the child's death. The purpose of this Strategy meeting was to share information about the family and the circumstances of the death with a view to ensure the safety and welfare of the surviving sibling. Conversations were conducted with two paediatricians, a social worker, two police officers, a specialist safeguarding nurse and a paramedic who had also been part of the ambulance crew that attended the family home in response to the emergency call. As a consequence of the initial conversations a further conversation was held with the Coroner's Officer who had not been present at the Strategy meeting but who had been influential in decision making. The information gathered was used to add detail to the chronology of events after C40's death and to aid understanding of the operation of the Child Death Review processes.

2.7 The review undertaken within Devon about Children's Services involvement used aspects of the SCIE methodology for this review. A review team or case group were not set up due to the limited scope of the review and the unavailability of practitioners who had been involved in the case.

2.8 Although, as described above, elements of the SCIE methodology were used in collection of data for the review and for the analysis in the Health Overview the overview report did not use the methodology and is not presented using the methodology's structure.

2.9 Following the completion of the criminal proceedings further information about the findings of the post mortem became available to the review. Expert examination of the brain at the time of the post mortem examination indicated evidence of injury on at least two occasions and that at least some of the inter cranial bleeding occurred more than 48 hours before death and was likely to

have been caused by a rotational injury. The timing of this injury is uncertain and could have occurred any time from birth to two days before the child's death. The fatal injury appears to have occurred immediately before death and was consistent with rotational and impact head injury. This knowledge resulted in some amendments to the Overview Report.

## 3 Family Involvement

3.1 The parents of the child were informed by letter, delivered by the allocated social worker, that the SCR was being undertaken and were provided with information about the purpose of the review. Unfortunately due to the police investigations and subsequent criminal proceedings it was not possible to involve the family directly in the review.

3.2 The father was charged in relation to the death of C40 and was convicted of manslaughter after a guilty plea and is serving a custodial sentence.

3.3 Following the completion of the criminal procedures the family members were offered the opportunity to meet the Overview Author to gather their views and perspectives and to discuss the SCR process and outcome.

3.4 The Mother was seen at home by the Overview author accompanied by the allocated social worker. She was offered the opportunity to make any comments about agency involvement with her family during the time period covered by the review. She commented that contact with midwifery services after the birth of C40 had been much less than after the sibling's birth and she had felt rather isolated. She acknowledged that none of the professionals had asked her about the children's father, other than the health visitor who had visited after C40's birth. She commented that she had found the parenting course, which she had attended as part of the assessments in relation to the Care Proceedings in respect of the sibling after the death of C40, had been helpful and enjoyable and that it would have been helpful to have attended something similar much earlier. She did not recall having been offered this or any other targeted parenting support during the timescale of the review. She commented that the input by the Devon social worker following the referral by the GP had not been as helpful as she hoped. She had expected to be offered some support but the focus of the single visit had been on her relationship with the children's father and his financial support of the family rather than on her brother who had been the perceived cause of her concern. She did not feel that she had been offered anything as a result of this intervention. She also expressed concern that when C40 had been seen by the GP two days before his death he had not been fully examined. She had expected the GP to want to see him stripped off but he had only seen the baby in his carry cot dressed in a winter fleece.

3.5 The maternal grandparents were also seen at the same visit, although separately and, with the mother's agreement, they had opportunity to comment on services. Their main concern related to the contact arrangements with the sibling whilst the child was in foster care. This being outside the scope of the

review it was agreed that the allocated social worker would support them in any further action that was required. They also expressed concern that there had been little support offered to them or their daughter in relation to their bereavement. Although this had initially been offered it had not been forthcoming.They also expressed concern about the length of time taken for the care proceedings to be completed and number of social workers who had been involved with their family since the death of C40 which had impacted on their ability to trust workers. They had no comments about other services.

3.6 The mother was seen again by the Overview author and the SCR Panel Chair to feedback on the outcome of the review and to discuss publication of the report. She expressed anxiety that publication of the report would result in distressing attention from the media and members of the community when she was in a position to move on with her life with her surviving child.

3.7 The SCR Panel Chair and the Overview author saw the father in prison after the completion of the review and offered the opportunity to comment on agency involvement. He indicated that although he had been keen to be involved in the baby’s care he had found it tiring and stressful. He said that, on reflection, he should have sought some support, although he was unable to articulate the nature of that support. His perception of the service offered by midwives and health visitors was that it was focussed on the woman and he had not considered seeking support from them. He expressed his ignorance of childcare and child development at the time and indicated that he would have found some parenting education helpful. He had no other comments to make about services.

## 4 Contextual Information

4.1 During the time frame of this review services were provided for this family by primary health care (General Medical Practice), South Devon Healthcare NHS Foundation Trust (maternity services, paediatrics and emergency department), Torbay and Southern Devon Health and Care NHS Trust and NHS Devon (health visiting services), Devon County Council Children’s Services and Torbay Council Children’s Services (after the death of C40).

4.2 Torbay is a unitary authority with a population of 131,000 (2011 census)[6]. It is an area of high density population with 20.8 people per hectare compared with 2.2 for the South West. 21.1% of the population are children.

4.3 Torbay is within the top 20% most deprived local authority areas in England and most deprived local authority in the South West for rank of average score. Torbay’s relative position within the national model of deprivation has worsened in recent years. There are pockets of severe deprivation in Torbay, with around 15% (21,000) of the population living in areas in the top 10% most deprived in England. Torbay shows higher than national or regional levels of

[6] Torbay Council, Census 2011 Torbay Profile
http://www.torbay.gov.uk/index/yourcouncil/factsfigures/census2011.htm

child poverty with 23.7% of children living in families considered to be in poverty (reported income less than 60% median income).

4.4 The number of live births in Torbay has risen noticeably. Indicators that relate to the well being of children such as mortality rates, breastfeeding rates, smoking in pregnancy hospital admissions for unintentional or deliberate injuries do not compare favourably with national or regional statistics. The rates of children looked after by the local authority in Torbay, the rate of children in need and the rate of children subject to child protection plans are amongst the highest in England. The perceived level of 'troubled families'[7] in Torbay is equivalent to a rate of around 235 per 10,000 families, the England average is 178 and therefore Torbay is within the top quartile of local authorities.[8]

4.5 Following an integrated inspection by Ofsted and the Care Quality Commission of safeguarding arrangements in 2010 that judged services were 'inadequate', the Children and Young People's Services in Torbay were restructured and a Children's Partnership Improvement Plan implemented. An unannounced inspection of child protection services in March 2013 found that there had been significant improvements and judged services to be 'adequate'. This is in the context of a significant proportion of similar inspections resulting in services continuing to be judged 'inadequate'[9]

4.6 Devon is an area with "two-tier" local government and is divided into eight districts. The County has a population of 750,000 with a higher proportion of older residents. The 0-17 population, of approximately 140,000, accounts for around 18.9% of the resident population, a proportion lower than both regional and national averages. Devon is the third largest county in the country, however, it is also one of the most sparsely populated with a population density well below national and regional averages. The proportion of children entitled to free school meals is below the national average. The proportion of pupils with English as an additional language is significantly below the national figure.

4.7 The family lived within Teignbridge District Council which has a population of 127,000. The health of people in Teignbridge is generally better than the England average[10]. Deprivation is lower than average, however about 3,100 children live in poverty. Levels of breast feeding and smoking in pregnancy are better than the England average. There are, however small pockets of deprivation.

4.8 There are over 7000 live births in Devon which has increased over the last 5 years the birth rate in Devon has increased by 8.2%. The birth rate in the Teignbridge area is slightly lower than the rest of Devon, which is itself significantly lower than the national rate. Whilst teenage conception rates in

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[7] Department for Communities and Local Government. (2011) Tackling troubled families http://www.communities.gov.uk/news/corporate/2052302

[8] Torbay Council, 2012/13 Joint Strategic Needs Assessment for Torbay: The narrative; a life course understanding of the health and social care needs in Torbay http://www.torbay.gov.uk/index/yourcouncil/factsfigures/torbay201213jsna.pdf

[9] Ofsted (2013) Social Care Annual Report 2012/13 http://www.ofsted.gov.uk/resources/social-care-annual-report-201213

[10] Public Health England (2013) Health Profiles – Teignbridge www.healthprofiles.info

Devon are significantly below the national average, there is great variation within the county, with the highest rates in the most deprived areas, including the area in which the family lived.

4.9 Across Devon, at the time of the Ofsted inspection in April 2013, over 5,000 children were in receipt of a social work service of which 450 children were subject to child protection plans and 684 were in care. Government figures predict that there are 1,370 such troubled families in Devon.

4.10 A joint Ofsted and Care Quality Commission inspection of safeguarding and looked after children services in 2009 judged services in Devon to be adequate. An unannounced inspection carried out in April 2013[11] by Ofsted of child protection judged the services to be inadequate consequently a Children's Safeguarding Improvement Board led by an independent chair has been set up to oversee and monitor the impact and effectiveness of a Child Protection Improvement Plan.

## 5 Chronology of events

### Background

5.1 The subject of the SCR known as C40 died aged four weeks. The cause of death ascertained by post mortem examination was 'rotational/impact head injury', injuries comprised bruising to the scalp, a skull fracture, bleeding into the brain and the eyes. There was evidence of trauma immediately before death but also evidence of prior injury in both the brain and eyes at least two days before death, although the precise timing of this cannot be established. At the time of his death C40 lived with the parents and a sibling.

**The father**

5.2 The father of C40 originated in Devon, his parents split up when he was five months old and he and his mother moved away. GP records indicate that he had challenging behaviour from early in his childhood and returned to the care of his father when aged 7 years, after some unsuccessful attempts at shared care. Children's Social Care (CSC) had been involved in the other area in relation to sexually inappropriate behaviour exhibited by C40's father. His behaviour continued to give cause for concern and he was referred to Child Guidance. CSC in Devon were involved in order to provide a Section 7 report[12]

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[11] Ofsted (2013) Devon Inspection Reports
http://www.ofsted.gov.uk/sites/default/files/documents/local_authority_reports/devon/051_Inspection%20of%20local%20authority%20arrangements%20for%20the%20protection%20of%20children%20as%20pdf.pdf

[12] A court considering any question with respect to a child under the Children Act 1989 may ask the local authority to report to the court on such matters relating to the welfare of that child. The purpose of a Section 7 report is to provide the court with information and advice as to what (if any) orders should be made to promote the child's welfare. A Section 7 report may be required in cases of divorce and separating parents. If a child's parents have not been able to decide between themselves where their child is going to live and who with and when the child will have contact with the other parent a decision will need to be made by the Court about where a child will live.

when his father (C40's paternal grandfather) sought a Residence Order. C40's father posed a number of management issues for his family and when 8 years old an assessment by a Clinical Psychologist/Psychiatrist indicated that he was a disturbed child, with some learning difficulties, who had suffered emotional abuse and neglect. When aged 9 years he was subject of a Child Protection Conference due to sexualised and other difficult behaviour but was not placed on the Child Protection Register. He boarded fulltime at a special school between the ages of 10 and 13 years. He moved to another special school when aged 13 years. Neither of his parents was able to manage his care throughout school holidays and he was accommodated for periods in a children's home. When aged 11 years the police were involved when he made an allegation to a member of school staff that he had been sexually assaulted at school by another pupil. He also disclosed his own sexualised behaviour towards other children. Neither incident provided sufficient evidence for further police action. Involvement with CSC ended when C40's father was aged 16 and moved to independent living.

5.3 When aged 19 years, on the advice of his parents, he sought advice from his GP with a view to psychological support. No psychiatric issues were identified by the GP and he was advised with a view to counselling in the future if necessary. Although the father consulted with his GP, two years later, shortly after the birth of C40's sibling the GP did not associate the adult with the troubled child that he had previously known and did not consider the necessity to share information with other professionals.

**The mother**

5.4 The mother is also understood to have originated from Devon. The earliest information about the mother in the chronology is when she was aged 17 years and seeking contraception from her GP. It is noted in police records that the parents started their relationship when the mother was 17 years and the father 20 years.

5.5 Six months after the start of their relationship the mother became pregnant with her first baby, C40's sibling. The mother was living with her parents and younger brother; C40's father also lived there some of the time, although their relationship was on and off. By the time she was seven months pregnant the parents' relationship had broken down, however they reconciled around the time of the birth of C40's sibling.

**Devon Services**

5.6 The mother and C40's sibling were provided with routine, universal care by midwives and health visitor during her pregnancy and after the birth.

[13]Although the mother was only 17 years old the maternity service Teenage Pregnancy Pathway, devised for use with mothers under 20, was not used to plan additional support and intervention with her. This may have been because

[13] Comments and author's analysis are included in shaded boxes throughout the narrative chronology

she was living with her own parents and therefore well supported, or as indicated in the Health Overview that the situation of teenage pregnancy was so common in the area that it was normalised by staff and therefore not considered worthy of additional consideration. Use of the pathway would have promoted liaison between midwives and the health visiting service during the pregnancy and a more proactive approach in engaging the mother in services such as those offered by Children's Centres.

The family were provided with the universal health visiting service in which is largely reactive, the more proactive Universal Plus service was assessed as being unnecessary as the mother was living at home with support from her family. There were minimal contacts between the family and health visiting service, in part due to the mother's failure to engage with services offered through the Children's Centre.

5.7 The mother sought advice from her GP about mild postnatal depression when C40's sibling was 2 months old. She disclosed finding the demands of the baby stressful especially when her partner and her mother were at work. It was noted by the GP that the mother had signed a form to allow information to be shared with Sure Start / Children's Centre. There is no indication of communication between the GP and Health Visitor following this consultation to provide the health visitor with information about the mother's condition and concerns. It is noted that although the Children's Centre attempted to make contact by letter with the mother, she did not respond and therefore was not offered services.

5.8 During contact with the Health Visitor when the baby was three months old the mother disclosed there having been family arguments. The mother expressed interest in attending a Children's Centre and joining a Teenage Parent group. Although the health visitor recognised some vulnerabilities these were not enough to lead to the identification of need for additional services. The mother had support from her own parents. The health visitor had minimal contact with the father, having seen him briefly only once on a home visit. Although the mother was offered opportunities to engage with activities and expressed an interest in them she did not do so and there was minimal on-going contact between the health visitor and the family.

There was an expectation by both the health visitor and the Children's Centre that the mother would be able to access additional support through her own volition. This is well recognised as a challenge for young mothers who do not find it easy to engage with services unless offered additional support. When she did not access the service some follow up to further encourage and support her would have been beneficial.

5.9 By the time this baby was five months old the mother was pregnant with her second baby (C40). At the time of the booking appointment with the midwife information about the mother's health and social history was collected and details of the father were also noted. The mother received consultant led maternity care due to her significant weight problems.

> The mother was still a teenager at the time of her pregnancy but again the Teenage Pregnancy Pathway was not followed. Considering the short interval between pregnancies additional support that may have been offered through its use would have been appropriate.

5.10 Two weeks after this booking appointment, there was communication between the health visitor and a practitioner for Devon MASH (Multi-agency Safeguarding Hub), who was requesting background information with respect to a referral to MASH by the police in respect of the mother's brother who had been reported missing from school. It was noted, as part of the referral that he had been physically and verbally abusive to family membership including the mother, whom he had physically assaulted. The police notification of this incident had been sent to the Named Nurse for safeguarding within the community health services but the information was not more widely shared with other health practitioners (GP, midwifery service). The MASH practitioner did not seek information from other health practitioners who were known to be involved (GP, midwifery service). There was no Children's Social Care intervention as a result of this referral. There had been ongoing parental concern about the mother's brother but previous referrals to Devon Children's Services and CAMHS had not resulted in intervention, his needs not having met the required threshold. Interventions were offered through a "Team around the Child" plan.

5.11 The following month, when she was thirteen weeks pregnant the mother saw a GP who diagnosed a depressive disorder linked to social stresses, including being a teenage parent with financial difficulties and an ambivalent relationship with her parents. It was noted that her relationship with the father of her child was intermittent and that he had recently left. She was referred for counselling and the GP made a referral to Devon MASH because of the GP's concerns for the welfare of the mother, her 7 month old baby and the unborn baby with respect to her general social circumstances and the violent behaviour exhibited towards her by her brother. The mother was accepting of the referral. There is no indication that details of the consultation or referral were shared with the Health Visiting or midwifery services.

> This was a missed opportunity for information sharing between health professionals who were working with the mother. The community midwives who hold clinics within the GP practice are able to access GP records and record information on these records. Health visitors are not based within GP practices and do not, therefore have routine access to recording by GPs. Even when practitioners have access to one another's professional records, unless issues or concerns are actively 'flagged up', they may not be noted. Details of referrals and other issues that are significant to the care provided by primary health care professionals to families require active information sharing between practitioners. There is also often an erroneous assumption made by practitioners in other agencies that 'health' is a single agency and communication with one practitioner, such as the health visitor, will result in other practitioners also being aware. Whenever a safeguarding referral is made to another service, such as Children's Social Care, it is good practice for health

practitioners to ensure that other health professionals who are also actively working with the family are also made aware. Where referrals relate to very young children and pregnant women, it is essential that the health visiting and midwifery service are made aware, such as through routine copying of referral forms.

5.12 Five days after the referral there was contact from a practitioner in MASH to the health visitor to ask for background information on the family. The last health visiting contact had been 4 months previously. There was no direct contact by the MASH with either the GP or with the midwifery service.

It may be of significance that the MASH practitioner was a health visitor and therefore the communication was between colleagues; however it would have been appropriate for the MASH practitioner to communicate directly with other health professionals or for it to have been an explicit task for the family's health visitor to do so and feedback to MASH.

The Devon Children's Services review notes that the referral record provides detailed information about the mother's brother and previous referrals in respect to him. This detail and the structure of the record may have led to a loss of focus on C41 and unborn C40, as subjects of the referral. It is noted that these limitations are being addressed in changes to the IT system.

5.13 Two weeks after the referral a social worker and a student social worker, who had been allocated the case, made a failed attempt to visit. The following day the health visitor attempted to make contact with the social worker and also discussed the case with the midwife. As a result of this discussion, the midwife completed an Interagency Communication Form which was copied to the GP, health visitor, public health midwife, Wellbeing and Access team (Adult Mental Health Services), Domestic Violence Team and the Children's Centre (as per normal procedure) which summarised details of the family circumstances and indicated actions to be taken by the midwifery service, including making a referral to the Perinatal Mental Health Team.

The Interagency Communication form was introduced into local midwifery practice in the area following a previous SCR. It ensures that relevant professionals, both health professionals and others, are made aware of any significant issues that may affect the safety and well-being of pregnant women and, especially, their unborn babies. This is an example of good practice and an indication of learning from other SCRs.

5.14 The social work student visited the family home the following week, met with the mother, maternal grandmother and C40's sibling and thereby completed an Initial Assessment. The outcome of the assessment was that the mother would take steps to seek alternative accommodation, apply for benefits and make financial and contact arrangements with the father. The assessment did not identify any risk to the baby or the unborn baby (C40). There was no direct contact made with the father who was not resident with the mother at the time. The mother was advised to bid for alternative accommodation, to make an application for benefits and to regulate contact and maintenance arrangements

with the father. It was also agreed that the mother would access a young parents group and attend relevant health appointments.

It is of concern that the case was allocated to a student social worker, the lack of documentation and the failure to see the mother alone or to speak to the father as part of the assessment are considerable weaknesses. The Devon Children's Services review indicates that the student was experienced, in their final placement and had had previous contact with the family in respect of the mother's brother when he had shadowed a visit to the family home. The focus of the assessment appears to have been blurred by this previous contact and there is little evidence of analysis of the mother's parenting or her ability to protect her child and unborn child especially when she was subject to verbal and physical violence perpetrated by her brother. It is also suggested that the shift of focus of the assessment away from the mother also resulted in the lack of appropriate consideration of the need to engage with the father as part of the assessment process. A sufficient level of management oversight of the assessment is not evident and the lack of clarity of the focus of the assessment, which had been on the grandmother and her son rather than on the pregnant mother and her child, was not appropriately challenged.

Had there been more liaison between the social worker and health practitioners it would have become evident that the mother often previously failed to follow through on agreed actions and that the apparently agreed plan may have been unrealistic and there was no clear strategy to confirm whether outcomes had been progressed or achieved.

5.15 The case was closed by CSC two days after the home visit, this was confirmed in a letter to the mother two weeks later, indicating that there would be no further role for CSC. There was discussion between the student social worker and the health visitor. The social work practitioner confirmed the conclusion that there was minimal risk to C40's sibling from the uncle but indicated that the child appeared to be lacking stimulation and it was agreed that the health visiting team would attempt to encourage the mother to attend a young parent's group. There is no indication of feedback to the GP who had made the referral of the outcome of the assessment.

It is of further concern that the GP as the initial referrer was not consulted as part of the Initial Assessment nor informed of the outcome, especially as it was decided that there should be no further intervention by Children Services. It would appear that there was an expectation that the health visitor would act as a liaison between the health professionals. The involvement of GPs in safeguarding processes has traditionally and stereotypically been seen as problematic by other practitioners, especially Children's Social Care[14]. In this

[14] Horwath, J & Morrison, T (2007) *Collaboration, integration and change in children's services: Critical issues and key ingredients* Child Abuse & Neglect 31 (2007) 55–69
Birchall E. and Hallett C. (1992) *Working Together in Child Protection. Phase I,* University of Stirling: Report to Department of Health
Hallett, C. (1993) *Working Together in Child Protection. Phase* III, University of Stirling: Report to Department of Health
Lupton, C, North, N, Khan, P (2001) *Working Together or Turning Apart?: the National Health Service*

case the GP initiated the referral and should have been more directly involved in the assessment and certainly should have been informed of the outcome.

The social worker's assessment that C40's sibling, aged 7 months, was 'lacking stimulation' should have prompted a more proactive approach by the health visitor to support the mother to access services through the Children's Centre.

5.16 There was liaison between the health visitor and midwives to make the midwife aware of the outcome of the Initial Assessment. As identified there had been no direct communication with the midwife as part of the Initial Assessment.

5.17 A month after the referral, a week after the case had been closed by Children's Social Care, the GP who had made the referral saw the mother as a planned follow up of the previous consultation. The mother indicated that the situation had improved as she was living mainly with the father, although it is unclear where. The mother expressed concern that the social worker had not spoken to her alone but had let her mother dominate the conversation. The GP having not received any feedback from MASH about the referral or assessment appropriately expressed concern by e-mail to MASH about the report from the mother about the social work contact, but did not escalate the concerns further.

The response to the GP's referral was a missed opportunity for a coordinated interagency approach to assessing and meeting the needs of the family. Having encouraged her to seek her own accommodation her ability to live independently and safely meet the needs of her child remained un-assessed.

5.18 The following day a midwife referred the mother to the Perinatal Mental Health Service after completing a Prediction and Detection Screening Tool that suggested continued depression. A week after the referral the Perinatal Mental Health nurse contacted the mother by phone, having liaised with the midwife. The mother's situation, mood and relationships were discussed. No further intervention by the service was required, she was encouraged to go to the Children's Centre, to contact the health visitor and she was sent information about the Depression and Anxiety service to which she could self-refer in the future if she felt the need. The telephone contact was followed up by a reflective letter to the mother, copied to the GP, HV and midwife.

It became obvious when analysing the chronology that the mother was able to present to practitioners as keen and able to follow through with agreed plans but seemingly unable to sustain the stated motivation and act in the way that she had agreed. This was also identified in the health overview and was also clear in the contact with Children's Services.

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*and Child Protection Networks.* Bristol, Policy Press

5.19 The health visitor saw the mother at home three weeks later during the 21st week of the pregnancy when C40's sibling was nine months old. The child was described as a happy, sociable and responsive baby. The mother discussed her relationships with her partner and her parents; she described being financially reliant on her parents. The health visitor advised the mother about feeding and stimulation of the baby.

5.20 Two weeks later a police intelligence log describes the mother as depressed and feeling suicidal, it is noted that her brother has been physically and verbally abusive to family members, including a physical assault on the mother that had not been reported to the police at the time. This information was passed to Devon MASH and recorded that the family would be supported through CAF.

5.21 Two weeks later the case was discussed at a Locality Multi-agency forum meeting. The chronology does not identify who was present at this meeting, which is described as "a weekly multiagency meeting in the locality to discuss low level concerns". It was noted that the Children's Centre were to ascertain progression of an application for independent housing, that the lead professional for the mother's brother would request an update and that the Youth Offending Team could offer support to the mother's brother's school via a referral to the Early Intervention Project.

5.22 On the same day the father was seen by his GP to discuss his weight and acne, he was offered dietary advice and medication. There is no indication of wider ranging discussion that took account of his previous history or his current social circumstances. This was the second time that the father had consulted a GP about being underweight. He had been seen nine months earlier, just after the birth of C40's sibling when the GP had completed armed services entry forms. There is no indication that the GP was aware of or enquired about the father's status as a father.

5.23 Over the next two weeks the midwife made many failed attempts to contact the mother. Subsequently when she then attended an antenatal appointment, the health visitor had opportunistic contact. The mother informed her that she was moving into the Torbay area in 2-3 weeks time where she would be living with her partner, away from her parents and brother. The health visitor advised her about reregistering with a GP in the locality when she moved. There is no indication of liaison with the midwifery service at the time about the forthcoming move. The health visitor made a number of unsuccessful attempts to make contact with the mother over the following two months. The midwifery service was then alerted to the possible move.

5.24 The mother had a number of hospital antenatal contacts over the next few weeks including growth scans which suggested low foetal growth although were difficult to interpret due to the mother's obesity. The community midwives continued to have difficulty making contact and when it was ascertained that the mother had moved to Torbay she was encouraged to register with a new GP and make contact with the local midwifery team. However the mother was

seen several times by a midwife in the Devon GP surgery and had one admission to hospital due to possible early labour.

5.25 During the 38th week of the pregnancy the mother was seen by a community midwife at the GP surgery in Torbay, having registered there.

5.26 C40 was born in hospital and discharged home the same day to the flat in Torbay. A discharge summary was sent to the Devon GP practice. The mother and baby were seen at home by the Torbay midwifery team on days 1 and 5 with telephone contacts on the day of discharge and day 11.

5.27 When C40 was 10 days old the sibling was seen by an out-of-hours GP with an upper respiratory tract infection and a rash; he was taken to the appointment by the father.

5.28 The Devon Health visitor attempted to visit the family for a routine primary birth visit on day 12 but failed to gain access to the family home. The family home was an upstairs flat with a ground floor outer door with no entry phone or similar, making access without prior arrangement difficult. Although the family were in Torbay, the birth notification and discharge information had been sent to the allocated health visitor for the Devon GP practice and therefore the case responsibility fell to the Devon health visitor. The health visitor initially felt constrained by policy not to transfer the case to a health visitor who, although more local, was in a different area. However, because of her failure to make contact with the family and the travelling distances, she did request a Torbay health visitor to visit the family and left the records in the Torbay health visitors' office. There was no formal handover.

## Torbay services

5.29 The Torbay Health Visitor clarified the family's whereabouts, the current registration with a Torbay GP practice and the situation with the midwifery team and arranged by text message to the mother to visit the next day – day 13.

5.30 When the health visitor visited the home the mother asserted that she was unaware of the visit as her phone was not working and therefore the visit was short. The sibling was seen playing alone but interacted appropriately with the health visitor. The child was clean and well dressed. C40 was described as clean and appropriately clothed, the mother handled him with confidence although the health visitor noted limited mother to baby communication. The parents were said to be cohabiting and the father was in the home but was not seen. The health visitor visited again later the same day to complete the Family Health Needs Assessment. A number of issues were identified that indicated a need for targeted health visiting intervention[15]. The health visitor discussed the family at her supervision with the Safeguarding Nurse the following day.

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[15] Health Visitors practice a system of progressive universalism; all families with young children have access to a universal service as defined by the Child Health Promotion Programme (Department of Health, 2009). Where additional needs are identified additional services are offered to meet those needs, with the most vulnerable children and families being offered the most intensive support.

The previous involvement with the health visitor had been at the universal level. The higher level response than in the previous episode of care with C40's sibling may have been prompted by identification of a higher level of need by the practitioner because of the new circumstances – two very young children with young parents newly living apart from the mother's extended family; alternatively it may have been due to individual practitioner differences in perception of thresholds or a more pervasive acceptance of lower standards in the previous area. This illustrates the importance of management oversight and supervision to offer challenge to practitioners about assumptions and potential normalisation of compromised parenting.

5.31 The next week the health visitor made a third home visit. Initially both parents and both children were present but father left shortly after her arrival, he was noted to be friendly. The maternal grandmother was also present during the latter part of the visit. C40 was observed to be a bit snuffly but otherwise well. The mother said that she planned to take the baby to the clinic that week; she did not however do so. The mother indicated that her mood was better than it had been ante-natally and that she had bonded well with the baby. The health visitor discussed any potential risks to the children posed by the maternal uncle.

5.32 The health visitor visited the family again a week later as planned. The mother and two children were seen. C40 was described as feeding well although very hungry, looked well although snuffly and had a mark on the end of his nose said by mother to have been caused by him scratching himself during the night. The health visitor noted that although she was holding the baby there was little interaction with him. The sibling, now 14 months old, was observed cruising around furniture and able to walk well with hands held. The sibling was said to have a good appetite and was sleeping in the parent's room. The mother initially appeared cheerful but during the visit disclosed negative thoughts including suicidal thoughts, although was clear that she would not act on them. An Edinburgh Postnatal Screening scored 20[16]. The health visitor arranged for mother and baby to be seen by a GP that day and it was arranged that the sibling would be taken to the clinic two days later to be weighed.

5.33 Immediately after the visit the health visitor left a telephone message for the GP about the mother's depressive symptoms and the baby's injury. The GP saw mother and baby that day. The mother was to be referred to the Depression and Anxiety Service[17] with a view to increasing her self esteem and it was planned that the health visitor would provide weekly contact. The mother expressed interest in attending mother and baby groups. The baby was seen

[16] The Edinburgh Postnatal Depression Scale (EPDS) is a 10-item questionnaire that was developed to identify women who have postnatal depression. Items of the scale correspond to various clinical depression symptoms. Overall assessment is done by total score, which is determined by adding together the scores for each of the 10 items. Higher scores indicate more depressive symptoms. Scores of 10 or less are considered normal. Scores of 13 or more suggest significant depression.

[17] An adult psychological therapy service offered by Devon Partnership NHS Trust accessed by GP or self referral

and examined and other than the scratch on his nose there were no other injuries identified.

5.34 The next day the health visitor attempted liaison with the GP and spoke to a different doctor who passed on the findings of the previous day's consultations. The health visitor and the GP who had seen the mother and baby spoke the following day. The health visitor attempted to visit the family as the clinic appointment for the sibling had been missed. When she was unable to make contact, the health visitor asked a colleague to visit the home the next day in her absence. This did not occur due to illness but another member of the health visiting team delivered a message giving a date for a further visit the following week.

5.35 The health visitor was unable to contact the mother on the arranged date and left a card asking her to make contact. Two days later there was another ineffective contact, the maternal grandfather was sought out and was requested to ask the mother to contact the health visitor and to attend clinic the following day.

5.36 That clinic appointment was attended by the mother and two children accompanied by the maternal grandmother. C40 was still unwell and was said to be vomiting and have unusual stools; other family members were said to have had diarrhoea and vomiting. C40 was described as looking unwell although alert with normal colour but crying pathetically at times, the weight gain had been satisfactory although on a low centile. The lesion on the nose had worsened and there was another similar mark on the cheek, the mother said that she thought that they might have been caused by the sleeping bag zip. The health visitor was concerned by the baby's clinical presentation and urged the mother to see a GP that day and contacted the surgery to alert them, asking to be informed if an appointment had not been made. Later in the afternoon when an appointment had not been made the health visitor texted the mother to remind her.

5.37 The baby was seen the following day by a GP who had not seen C40 previously. The doctor did not carry out a full examination of C40 but checked for signs of infection whilst the baby remained asleep in the carrycot throughout the consultation. C40 was described as having the appearance of a normal healthy baby. His mother said that he was feeding well and indicated that the lesion had not changed significantly in the previous two days. The lesion on C40's nose was diagnosed as resolving impetigo[18] and an ointment prescribed. The mother was advised to take the baby to A&E should there be any deterioration or a rise in temperature over the weekend. The health visitor was informed of the consultation when she contacted the surgery.

| This health visitor's persistence in ensuring contact with the mother and in following up the doctor's appointment is a marker of good practice and is an indicator of the heightened concern for the wellbeing of this baby. |
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[18] A common contagious skin infection, which causes sores and blisters, it mainly affects children, although unusual in very small babies.

Although the health visitor had alerted the surgery to her concerns there does not appear to have been any direct contact between the health visitor and the GP who saw C40 on this occasion either before or after the consultation. In view of the health visitor's significant concern about the baby's health and, with hindsight, the possibility that the baby had suffered a rotational head injury at some point more than 48 hours before the fatal injury, it is of concern that the GP who saw C40 on this occasion only did a limited assessment. It would have been better practice for the baby to have at least been handled to allow assessment of the muscle tone and general condition. In light of the two marks on the baby's face (diagnosed as impetigo which is very unusual in young babies), the young age and vulnerability of the baby and the previous consultations about the mother's welfare, it may have been appropriate for the child to have been fully examined in the nude. The mother herself indicated surprise to the overview author that the baby had not been fully examined. The clinical concern of both professionals was that the baby was suffering from an infection and therefore normal temperature, respiration and heart rate would have been reassuring and reduced the necessity for further physical examination. The determination of the need for full naked examination of babies is a professional judgment which is frequently exercised by a number of health professionals, especially GPs, HVs and midwives and the clinical decision to do so must be weighed against the impact of disturbing a sleeping child (a woken baby will generally cry making examination difficult and it is often seen as unhelpful by parents who may have struggled to settle an unwell child) and the time taken to undress and redress a baby. The most likely cause of illness in a young child is infection and any form of injury including head injury would be an unusual finding but not one that can be overlooked. There is currently no nationally agreed standard for health professionals about the criteria for undressing babies for clinical examinations and it would be helpful for the professional bodies to give this consideration. The Department of Health sponsored clinical educational resource Spotting the Sick Child (2011)[19] should be reviewed to ensure that there is an appropriate focus on safeguarding issues.

5.38 Two days later in the early evening an ambulance was called to the home where C40 was not breathing. The grandfather was instructed about CPR over the phone and when the ambulance crew arrived resuscitation attempts were continued. C40 was unresponsive, very cold and without a pulse. C40 was transported to hospital by ambulance and resuscitation attempts were continued for over an hour before life was declared extinct. The parents were present at the hospital, in the resuscitation room, some of the time and were kept fully aware of what was happening.

5.39 The procedure for investigations to be undertaken on the sudden death of a child was generally followed[20]. This included full examination by a consultant paediatrician and collection of relevant specimens of body fluids. The protocol

[19] www.spottingthesickchild.com
[20] South West Peninsula Child Death Overview, Protocols and Working Procedures (Reviewed February 2012)

provides a checklist of investigations to be followed. A skeletal survey was not done, although included as part of the protocol. Contact was made with the Out of Hours Social Care service however it was noted that there was no social worker available that night for a multiagency discussion, which was postponed until the following day. It was noted that there was no allocated social worker at the time. The Child Death Overview Rapid Response Team was not notified at the time.

The Child Death Protocol requires that the Rapid Response Team is informed of all unexpected deaths of children under the age of eighteen. This would normally be done by the paediatrician receiving the child into the Emergency Department or by the investigating police officer. A Specialist Practitioner would then meet with the Paediatrician, Police and the family in the Emergency Department for initial information sharing and to plan a visit to the home to complete the review of the history and circumstances of the death. The failure to notify the Rapid Response Team was a significant oversight and missed opportunity.

5.40 In line with the protocol a police officer from the Public Protection Unit (PPU) attended the hospital. The officer was on call from another geographical area. The on-call consultant paediatrician and the police officer examined C40. The baby was noted to have two bruises either side of the forehead, a small red mark on the back of the head slight bruising to a finger and on the chest. It was also noted that the cerebrospinal fluid specimen was blood stained. At the time these findings, whilst of some concern, did not arouse a high level of suspicion of non-accidental injury and therefore the death was considered at the time to have been a SUDI (sudden unexpected death in infancy). The police officer, however, asked if a skeletal survey could be performed.

5.41 The on-call paediatric consultant and police officer saw the parents and grandparents in the early hours of the morning and took a full history of C40 and the events preceding his death.

5.42 The Coroner's Officer was informed of the death later in the morning, in office hours. The Coroner's Officer informed the Coroner of the death and it was agreed that arrangements for a post mortem would be made with Great Ormond Street Hospital.

5.43 On the afternoon after the death, a Strategy meeting was held in the hospital to consider the safeguarding needs of C40's sibling. It was attended by the consultant paediatrician who had been involved the previous night, a second consultant paediatrician who was the named doctor for safeguarding children for the hospital, a social worker and practice manager from Children's Social Care, two specialist nurses for safeguarding children, two police officers from the local PPU and a paramedic who had been one of the ambulance crew who had attended the family home and conveyed C40 to hospital. An administrator from Children's Social Care minuted the meeting.

There were differences in perceptions of this Strategy meeting between professionals. It was the understanding of the police officers that such a

meeting would be held in any circumstance where a child had died unexpectedly. The Child Death Protocol includes this multiagency discussion early in the process whilst the child is in the hospital emergency department. This occurred but due to the time minimal information was available. The police officer therefore anticipated that the discussion would be continued the next day at a multi-agency meeting. The perception of health professionals was that the meeting was a specifically called Child Protection Strategy meeting triggered by the previous referral of the family to Children's Social Care and therefore an increased need to consider the welfare of the surviving sibling. The conduct and the outcome of the meeting were not, however unduly influenced by the differences in perception of the purpose.

5.44 Having not been informed of the death or the meeting there was no representative of the Child Death Overview, Rapid Response Team present; the police officer from the local PPU contacted them after the meeting.

5.45 The social worker provided background information about previous contacts with Children's Social Care. The paediatrician described the circumstances leading up to the death as explained by the family members. There was discussion about the fact that the baby had been very cold on arrival at the hospital. It was noted that the flat had been cold because the heating had not been available. There was discussion about the possible bruising on the baby; the paediatricians were unable to offer a definitive opinion about whether bruises had been a result of the resuscitation attempts or whether they had been inflicted earlier and were thus unable to determine whether or not the death was at all suspicious. Body maps and photographs of the baby were shown to the meeting. The safeguarding nurses shared information about health visiting input to the family. None of the professionals present had any detailed knowledge of the father.

5.46 There was discussion about the need for a skeletal survey; the presence of any bony injuries would have significantly increased suspicions about the cause of death and indicate a need to consider urgent action to safeguard the surviving sibling. It was noted that a post mortem examination would be carried out at Great Ormond Street Hospital, the nearest pathology department that undertakes paediatric post mortem examinations, and that a skeletal survey would be part of that examination, although the timing of this was yet to be determined as this was the responsibility of the Coroner. The Coroner was neither present at the meeting nor consulted subsequently; all negotiations were undertaken with the Coroner's Officer.

5.47 A plan was made at the Strategy meeting for a skeletal survey to be completed at Torbay Hospital, Children's Services would offer support to the family and complete a core assessment in respect of the sibling, the health visitor would assess the sibling's development and offer support. It was acknowledged that there was no role for the police unless there were indications that the death was suspicious. There was no plan for the sibling to be medically examined. It was agreed that the meeting would be reconvened once the post mortem examination had been completed.

5.48 The Named Doctor spoke to the Coroner's Officer after the Strategy meeting and was told that it was a policy that skeletal surveys would not be carried out locally but would always be done at Great Ormond Street Hospital as part of the post mortem process. Consequently it was agreed that Children's Services would ask the grandparents to supervise the sibling with his parents at all times.

5.49 There was further discussion between the responsible police officer and the coroner's officer about the need for a forensic post mortem. In consultation with the pathologists it was agreed that the initial post mortem would be conducted by a paediatric pathologist but that a forensic pathologist would be available to complete the examination if initial findings indicated that this was necessary.

5.50 Two days after the death a member of the Rapid Response Team visited the family home with a police officer, as required by the unexpected death protocol, albeit later than expected by the protocol.

5.51 Three days after the death the initial post mortem examination, carried out at Great Ormond Street Hospital, indicated that C40 had significant and suspicious injuries. A forensic pathologist completed a full forensic post mortem examination the next day with the responsible police officer was in attendance. The post mortem examination revealed the cause of death as impact and rotational head injury, and indicated that there was evidence of injury on at least two occasions, one of which was more than 48 hours before the death. As a result of the findings of the post mortem examination C40's sibling was taken into police protection and placed in foster care. An Emergency Protection Order was granted the next day. A Paediatrician examined the child the same day and no injuries were identified.

5.52 Care proceedings were instituted and the child was initially placed in foster care. Court proceedings resulted in Torbay Council being granted a Supervision Order and the child has subsequently been returned to the care of his mother.

## 6 Analysis

6.1.1 The health overview identified a number of areas of good practice relating to the involvement of health practitioners who provided services to this family. It identified that there were the expected professionals involved with the family, at times with a higher than expected level of support and particularly efforts to maintain contact. Appropriate referrals were made to specialist services (antenatal, mental health and multiagency). Information in referrals was accurate and established referral forms / methods were used.

6.1.2 The health overview review team also found evidence of good practice and hard work by those involved (particularly to repeatedly chase up non engagement). Staff demonstrated clear recognition of their accountability to continue service provision, at times travelling considerable distance or making many calls to family members. In the feedback meetings there was consensus

that this family were ‘typical’ of the case load. However the review team found great variation in perception of what was ‘normal’ or acceptable, in particular mother’s (and father’s) ability to meet the children’s needs.

6.2 A number of themes were identified and have been used to analyse the professional involvement with this family prior to the death of C40.

6.3 **Assessment**

6.3.1 “The effectiveness with which a child’s needs are assessed will be key to the effectiveness of subsequent actions and services and, ultimately, to the outcomes for the child. p viii”[21]; “Fundamental to establishing the extent of a child’s need is a child-centred, sensitive and comprehensive assessment. p28”[22] As suggested by these quotations good assessments are fundamental to identifying and addressing the needs of children. However assessment is a complex activity and the quality of assessment is key to the significant decisions that affect outcomes for children in both the short and long term.

6.3.2 Good assessment of the needs of children requires practitioners to take full account of all of the relevant information including the history of the parents. Information needs to be gathered but in order to understand how that information will impact on the health and welfare of children it needs to be analysed.

6.3.3 Assessments of adult relationships are often crucial to the understanding of children’s lives. Throughout the life of both children health professionals sensed that the parental relationship was at various times unsteady with ambivalence of parents towards each other. None of the professionals had an open dialogue with mother about her longer term wishes or intentions, other than her desire to move away from the parental home. When professionals were aware of relationship issues, there were missed opportunities to share information with other practitioners, such as at the time of MASH referral and later when referral was made to the perinatal mental health service. These gaps in information led to loss of awareness of possible risks within the family, especially consideration of parenting capacity.

6.3.4 There was a failure to take full account of the mother’s age when assessing her need for services and, to some extent at least, the fact that she was living with her parents detracted from assessing her needs as an individual and as a teenage mother. When a student social worker undertook the initial assessment the mother was not seen alone and information was gathered from the maternal grandmother. The focus of this assessment was not clear and became directed towards the needs of the grandmother and her son and away from the mother and her children, who had been the clear focus of the referral. The mother was perceived as a child within the family rather than a young mother. This was raised as a concern by the referring GP but not addressed.

[21] Department of Health (2000) The Framework for the Assessment of Children in Need and their Families

[22] Lord Laming (2009) The Protection of Children in England: A Progress Report , Norwich, TSO

6.3.5 The referral by the police to MASH which stated that the mother had been kicked in the abdomen by her brother, was not recognised as a safeguarding risk, which of itself, should have led to a pre-birth assessment by Children's Services. It was also not fully taken into account when the initial assessment was undertaken following the GP's referral.

6.3.6 Assessment must be a dynamic process and the circumstances and needs of children should be reassessed regularly. The assessment by the original health visitor that a universal service was all that was necessary for this family was not updated in response to significant changing circumstances.

6.3.7 The health review team identified that although documented assessments were completed and that practitioners were specifically considering the risk of physical harm posed by the mother's brother some information that was 'knowable' was not taken fully into account. For example the social worker's assessment indicated concern that C40's sibling was not being adequately stimulated, a possible indicator of neglect. This was not reflected however in decision making and clear planning by the health visiting service to clarify the need for enhanced services and/or child protection supervision.

6.3.8 The lack of a comprehensive safeguarding risk assessment was particularly apparent when health staff found it difficult to transfer care to other team(s), when the mother was thought to have moved but had not notified all relevant health staff. Registration with a GP is a key step to service allocation for other health services, including community midwifery and health visiting. Whilst the mother remained registered in Devon, the case accountability fell to the practitioners there rather than those in the area in which she was living. The lack of transfer resulted in the mother not having health visiting antenatal contact and a delay in a primary visit after the birth of C40. This was identified as a significant issue in a previous SCR conducted in the area.

6.3.9 It would appear that the grandparents were providing a considerable amount of support to mother. Consideration of the source and amount of support was particularly pertinent during the period when she expressed a desire to move out of the family home. At the time, professionals saw this move as beneficial as it was a move away from potential risks posed by the mother's brother. However, likely reduction in support that went with independent living was not fully considered or discussed with the family, until the mother herself raised a worry after her move about her mental state and her ability to cope practically and financially. There was a lack of appropriate assessment and professional curiosity in the failure to consider the mother's ability to live and parent independently. There was no identified plan to assist her with this.

6.3.10 The outcome of the social work assessment was that the threshold for social work intervention was not met. The ensuing plan was dependent upon the mother accessing services herself, without testing her motivation or ability to follow this through. Further interagency communication would have identified concerns about her ability to effect change without significant support. The mother's identified depression would have further exacerbated these concerns. It would have been appropriate for a more formal plan to have

been put in place, involving 'a team around the child' to support the mother, albeit at a level below that of social care intervention.

6.3.11 After the initial contact by the new health visitor, following the birth of C40, she sought child protection supervision and it was identified that a more proactive approach to the family was required. The health overview identified that practitioners had acknowledged within feedback meetings, that the change to a proactive approach was both appropriate and more effective than earlier case management. As mentioned earlier, it is difficult to distinguish between this being a result of different individual practice, the impact of a 'new pair of eyes' assessing the family or a more pervasive normalisation of suboptimal parenting.

6.3.12 Good practice in considering and assessing for risk or actual physical harm was identified when risk to the unborn baby and sibling from the maternal uncle prompted a Multiagency Safeguarding Hub (MASH) referral by the police and after the child's birth when presenting with a facial mark treated as infection / impetigo was followed up promptly and assiduously by the health visitor.

6.3.13 When C40 was seen by the GP following the referral by the health visitor two days before his death, the limited assessment undertaken is of concern. The focus of the GP was to assess for signs of infection, which he was able to do without removing the baby from its carrycot. Further examination may possibly have alerted the GP to other concerns about the child, especially if an earlier head injury had been inflicted, albeit the timing of this is uncertain, (having occurred sometime between birth and two days before the baby's death). It is recognised that GPs have very limited time for consultations with their patients. However, in the case of a very young baby with an unusual presentation, such as impetigo, there would have been merit in undertaking a fuller examination and health assessment than is possible when the child is fully clothed in a carrycot. This is especially so when concerns had been expressed by another health practitioner and where there is limited prior knowledge of the child and family. There are professional challenges associated with examination of babies fully undressed and no agreed national or local standard to guide professional judgement.

### 6.4 Engagement with the mother

6.4.1 The mother's contact with health services was variable and at times erratic, although engagement was generally better where her children were concerned. Routine appointments for immunisations etc. for C40's sibling and most antenatal contacts were attended, although after the move away from the parental home these became more erratic. A number of practitioners were aware of Mother's lack of engagement as a repeating and concerning pattern but it was often taken at face value. Her lack of ability to follow through plans and the implications that it may have had on her longer term parenting abilities were not always taken into account, especially when she moved away from her parental home.

6.4.2 Teenage pregnancy can be a positive experience but is also associated with a wide range of subsequent adverse social and health conditions[23]. In addition, it is recognised that adolescents often find it difficult to access mainstream health, and other, services and therefore specific services are provided to facilitate access and to meet the specific needs of the age group. For this reason, a Teenage Pregnancy Pathway for mothers aged under 20 at the point of booking with the midwifery service was developed and introduced within the maternity service some time prior to C40's sibling's birth. However, the fact that the mother was a teenager during both of her pregnancies was not taken into account and consequently the Pathway was not used. This led to a series of missed opportunities for support and engaging targeted services. An example, cited in the health overview, was a failure by the mother to follow recommendations to attend the Children's Centre in the first weeks of the sibling's life, during her second pregnancy and again after her move. Services, such as the Children's Centre, were offered but with an expectation that the mother would access them by her own volition. Once it became obvious that the mother was unable or unwilling to access the services, more encouragement and support could have been offered.

6.4.3 The move into her own accommodation should have acted as a trigger for more targeted support, the additional support offered by her family having been cited as a reason for not being in receipt of an enhanced health visiting service.

6.4.4 The mother's capacity to function independently as a safe parent was not assessed. She was encouraged to seek alternate accommodation away from her family, in order to reduce the potential risk posed by her brother, but the potential impact on the welfare of her own child was not assessed by any professional. It is of note that contact with the midwifery service became erratic at this time and although there was good practice in continuing attempts to make contact, there appears to be little analysis of the reasons for the change in pattern.

6.4.5 The social work assessment failed to identify the mother as a separate unit from her wider family. The assessment comprised a single visit, when the mother was seen only in the presence of her own mother. This has been acknowledged by the practitioner as inappropriate and has contributed to development of the individual's practice.

### 6.5 Engagement with the father

6.5.1 As with teenage mothers, there is a wealth of evidence to support the importance of engaging young father's in the lives of their children[18,24]. Low levels of engagement of father's with welfare services are widely recognised as problematic and potentially detrimental to the welfare of children; potential risks are not identified nor are the possible positive resources that they may

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[23] DCSF & DH (2009) Getting Maternity Services right for pregnant teenagers and young fathers - 2nd edition

[24] The Fatherhood Institute (2013) *Fatherhood Institute Research Summary: Young Fathers*

offer[25]. Throughout the period of the review, the parents' cohabitation was on and off; he was however the father to both children and therefore of significance in their lives. Across the range of health services, there was little consideration of his influence in terms of support that he may be offering the mother, any risk that he posed or his parenting capacity. His presence or absence in the family was not given any consideration, details about him were not sought, and the mother was not asked about him or their relationship. His parenting abilities were not considered at any stage. This has been identified as a recurrent issue, for example Quinton et al (2002)[26] found that in 50% of cases health visitors did not even know the fathers' names in spite of the importance that the mother placed upon their involvement. The Health Overview review team found this to be common practice amongst practitioners, and although there are some prompts for information gathering in standard documentation and professional records such as the maternity hand held records, the level of staff knowledge of the need to "think father" was disappointingly low. This too was a feature of a previous local SCR. The need for this information to be regularly updated to ensure continued accuracy was also identified as an issue.

6.5.2 It is of particular concern that the review team identified a reluctance amongst practitioners proactively to seek information about family and household members, seeing such information seeking as unwarranted prying rather than a legitimate part of a process to assess the situations in which children are living and the influences on their lived experiences.

6.5.3 Another significant opportunity to engage father was missed when a health professional, seeing him to complete papers supporting a considerable career move, had no idea that he was already a father with a second baby on the way. There was also significant past information about his difficult childhood that was 'knowable' but not reviewed at the time. The father's experiences as a child may have had significant bearing upon his parenting capacity; this was not identified by the practitioner and consequently not shared with others. The failure by practitioners who deliver services for adults, both male and female but especially males, to take account of the adult's role as a parent and to consider their history and presentation in light of their parenting role and the impact upon the safety and welfare of children is a frequent feature in SCRs[27]. This has been recognised in statutory guidance *'When health professionals have concerns that an adult's illness or behaviour may be causing, or putting a child at risk of, suffering significant harm they should follow procedures set out in Ch. 5'*[28]. This however must be balanced with the limited time available to primary health care practitioners for consultations, which generally precludes detailed review of past records at every

[25] Maxwell, N., Scourfield, J., Fetherstone, B., Holland, S., and Tolman, R. (2012) *Engaging fathers in child welfare services: a narrative review of recent research evidence.* Child and Family Social Work, 17(2): 160-169
[26] Quinton, D., Pollock, S., & Anderson, P. (2002). *The Transition to Fatherhood in Young Men: Influences on Commitment. Summary of Key Findings*. Bristol: School for Policy Studies, Bristol University.
[27] Ofsted (2010) Learning lessons from serious case reviews 2009–2010
[28] HM Government (2010) *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children, London, TSO (¶2.84)*

consultation. This highlights the need for succinct summaries of significant events in individual's lives to be readily accessible to practitioners.

6.5.4 This lack of focus on the father as part of the family unit was also highlighted as a finding of the Devon Children's Services review. It was noted that, although information about him had been made available as part of the referral process it had not been included as part of the 'child's network'. Information was not gathered about him and his views were not sought as part of the initial assessment. Additionally the manager did not identify this omission when 'signing off' the assessment. The failure to engage fathers in assessments was also noted in the Ofsted inspection of Devon's Children's services.

### 6.6 Professional communication

6.6.1 This family should have been identified as one with additional needs beyond universal services; use of the Teenage Pregnancy Pathway and the South West Child Protection Procedures Unborn Baby Protocol may have stimulated a more integrated approach within health services as well as across agencies.

6.6.2 Although some practitioners developed health plans, there was only limited evidence of individual review and no joint review across professional groups. There was no indication of one practitioner taking a lead responsibility. This meant that there was information known to some practitioners but not others, which, in turn, prevented the opportunity to gather firmer evidence of lack of progress. It was identified that additional case support would have been helpful in this respect for this family to stimulate reflection on child in need and safeguarding thresholds. It was also identified that there had been issues with staff turnover and capacity in key leadership / support roles and felt this impacted on oversight of casework.

6.6.3 The health overview identified that there was a failure of wider team working and information sharing and identified that there was a prevalence of silo working. The three health services who provided care for this family; midwifery, health visiting and general medical practice worked in isolation with focus on their direct role with the family without giving consideration to wider health issues or the involvement of other services. For example, around the time of the mother's move practitioners realised the importance of handover from one group of professionals to another; they repeatedly raised this with the mother but did not identify it as an issue with other professionals, particularly to the GP. The lack of active liaison between MW, HV and GP at this point contributed to staff not realising that the mother was disengaging from several services and therefore the need to escalate their concerns via child protection supervision or consideration of the threshold for referral to other agencies. This silo working led to a lack of focus on the vulnerabilities of the family. This is an issue that is common in SCRs and it is noted that it is raised consistently within training, with specific efforts to share learning from relevant serious case reviews, including local ones. Clearly the learning has not yet been embedded in practice.

6.6.4 An important additional concern identified in the health overview was the lack of feedback from multiagency referrals, and perceived poor joint working. The review team noted a failure in everyday practice to pursue this or to escalate effectively, within their own organisation, as per South West Child Protection Procedures for 'deciding who should help' and 'escalation policy'.

6.6.5 The structure of the health service is complex and a range of practitioners from different organisations and specialisms provide care for a single family. This lack of homogeneity can be a challenge to other agencies and there is, at times, an expectation that when information is shared with one practitioner it will automatically be available to other health practitioners involved with the family. The range of individuals, organisations and recording mechanisms often impedes this and practitioners from other agencies need to take this into account. On each occasion that a MASH referral was made in relation to this family contact was made with the health visitor but not with other professionals involved with the family. This was especially significant when the GP made the referral and the social worker fed back information to the health visitor. Although it may be expected that practitioners will share information with colleagues in other professional groups it is essential that if there is an expectation that this will happen that it is made explicit and it would be helpful if there were systems to support this.

6.6.6 There are indications that GPs were, to an extent, marginalised from safeguarding practice. The father's GP records contained a significant amount of information that would have been relevant to assessments of his parenting capacity but because the information was not sought and the GP was unaware of the father's status as a father, it was not shared. It appears that information was not sought from the GP following MASH referrals and even when the GP made a referral, there was no feedback directly to them. When the Strategy meeting was held after C40's death, again no information was sought from the GPs. GPs are key gatekeepers to health services and should be fully involved in processes to safeguard children.

### 6.7 Management oversight and supervision

6.7.1 It is well recognised that good supervision and support is essential to good child protection

> *"The chaotic behaviour in families was often mirrored in professionals' thinking and actions. Many families and professionals were overwhelmed by having too many problems to face and too much to achieve. These circumstances contributed to the child being lost or unseen. The capacity to understand the ways in which children are at risk of harm is complex and requires clear thinking. Practitioners who are overwhelmed, not just by the volume of work but also by its*

*nature, may not be able to do even the simple things well. Good support, supervision and a fully staffed workforce is crucial."*[29] *p1*

6.7.2 This family should have been identified as one with additional needs beyond universal services, use of the Teenage Pregnancy Pathway and the South West Child Protection Procedures Unborn Baby Protocol may have stimulated a more integrated approach by practitioners in different parts of the health service as well as across agencies.

6.7.3 As previously identified, there were a number of occasions when a greater degree of management oversight may have led to a more robust and integrated approach to the care of this family. In spite of the mother's age, the Teenage Pregnancy Pathway was not used and this was not challenged. A degree of stereotyping of the family is evident in the attitude of practitioners that led to an acceptance of their circumstances without challenge. Opportunities for structured reflection may have challenged these perceptions and resulted in a more proactive approach in the care. When supervision was sought by the health visitor, the practitioner was supported in offering a more proactive approach.

6.7.4 The Devon Children's services review also identifies deficits in management oversight of the student social worker and indicates that it had been an area of weakness identified in the Ofsted inspection in 2013 and therefore part of the improvement plan already in place.

**6.8 Interface with the Child Death Overview Process**

6.8.1 Both editions of Working Together, 2010 and 2013 provide detailed guidance on the review of all deaths of children in line with Regulation 6 of the Local Safeguarding Children Boards Regulations 2006 made under section 14(2) of the Children Act 2004; this includes a requirement that LSCBs *"put in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death"*[30]

6.8.2 To fulfil this statutory requirement Torbay Safeguarding Children Board collaborates with the other LSCBs in the far South West and has agreed a joint Child Death Overview for the Peninsula. The processes to be followed are laid out in Working Together (Chapter 7 in 2010 and Chapter 5 2013). The Peninsula Child Death Overview process is supported by a multidisciplinary Rapid Response Team (RRT) for unexpected deaths, collating the minimum data set and information from other agencies involved with the child, and feeding this information into the joint Child Death Overview Panel (CDOP) for reviews to be undertaken. The personnel involved in the Child Death Overview process are hosted by one of the involved health

[29] Brandon M, Bailey S, Belderson P, Gardner R, Sidebotham P, Dodsworth J, Warren C and Black J (2009) *Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07,* DCSF

[30] HM Government (2013) *Working Together to Safeguard Children A guide to inter-agency working to safeguard and promote the welfare of children, www.education.gov.uk/aboutdfe/statutory Reference: DFE-00030-2013 (¶2.84)*

organisations. Each acute hospital trust has a local CDOP administrative co-ordinator to act as a link with the Peninsula office and ensure information about deaths is appropriately shared with the wider professional community involved with the child, as a longer term follow-up after the intervention of the RRT. The protocol requires that all deaths be immediately notified to the main CDOP office to trigger response from the Rapid Response Team if the death is unexpected.

6.8.3 Where a death is unexpected[31] the Coroner and the police become involved and the police begin an investigation into the circumstances on behalf of the Coroner. Any unexpected death must be reported to the Coroner and once the attending doctor has confirmed death, the Coroner assumes immediate responsibility for the body and, in most circumstances, no further samples for investigation may be taken without the Coroner's permission. The Coroner's Officer acts on behalf of the Coroner. In line with the Kennedy Report[32], the Child Death Overview Protocols and Procedures set out a range of investigations that should be undertaken in the case of unexpected child deaths that have been agreed by all Coroners in the South West peninsula. This overrides the need for consultation with the Coroner on each occasion.

6.8.4 The paediatrician with designated responsibility, in collaboration with the police, should initiate immediate information sharing with other agencies including Children's Social Care. This should lead to multiagency discussion to determine required action by agencies. The Peninsula CDOP includes a Rapid Response Team and Rapid Response Specialist Practitioners provide support to acute paediatricians and others in following the required procedures following an unexpected death, this may include a home visit with the police especially if the deceased is an infant.[33] The home visit with the police is required to gather information about the circumstances of the death. This information then feeds into any investigations, including those that fall within the jurisdiction of the Coroner and ultimately into the Overview process for all child deaths. The Rapid Response Team is commissioned to offer a Monday to Friday service and contact is made via an answerphone, messages are collected from 7am and sometimes on Sundays. The unexpected death of a baby is not a common occurrence and therefore most practitioners will be involved infrequently. The Rapid Response Team have greater familiarity with the required processes and have regular links with other involved specialist practitioners and are therefore able to offer support and guidance. The Rapid Response Practitioner would, wherever possible, be part of the initial discussions and information sharing about the child's

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[31] An unexpected death is defined as the death of an infant or child (less than 18 years old) which was not anticipated as a significant possibility, for example 24 hours before the death, or where there was a similarly unexpected collapse or incident leading to or precipitating the events which led to the death.

[32] Royal College of Pathologists and the Royal College of Paediatrics and Child Health (2004) Sudden unexpected death in infancy. A multi-agency protocol for care and investigation. The Report of a working group convened by the Royal College of Pathologists and the Royal College of Paediatrics and Child Health. Royal College of Pathologists and the Royal College of Paediatrics and Child Health, London. www.rcpath.org

[33] PJ. Fleming, P.S. Blair, C. Bacon, and P.J. Berry (2000) Sudden Unexpected Death In Infancy. The CESDI SUDI Studies 1993-1996. The Stationery Office. London. ISBN 0 11 3222 9988; and *ibid.*

death; their greater familiarity with such deaths allowing them to offer additional advice.

6.8.5 This step in the process was not followed and the RRT were not made aware of the death until the following day, after the strategy meeting, when the local police officer informed them, having realised that there had been no previous communication. It was identified that the local police team have developed an 'aide memoir' to ensure that all steps are followed. The officer who was in attendance came from a different area and did not have access to this. A message was left for the local CDOP administrator, in the belief that this would be relayed to the RRT. This did not happen immediately and it is not part of the remit of the local administrator.

6.8.6 The latest version of the Peninsula Child Death Overview Protocols and Guidance updated in November 2012 provides detailed guidance, including a pro-forma for completion on the examination of the child for all practitioners involved in the management after an unexpected death of a child. It recommends that skeletal surveys should be undertaken after the sudden unexpected death of a child under 2 years "as soon as possible after death" and gives responsibility to the attendant consultant paediatrician for "arranging skeletal survey in liaison with Coroner's Officer". The pathologist performing the post mortem examination always undertakes a skeletal survey. It emerged that there is reluctance for skeletal surveys to be undertaken locally as this would result in duplication. The need for radiological examination and reporting of a deceased child is an uncommon occurrence and may be extremely emotive. There is concern that without expertise and experience practitioners may inadvertently affect potential evidence and interpretation of X-rays may be more open to evidential challenge if undertaken by practitioners with limited experience. Therefore there is a balance to be struck, when considering the need to safeguard surviving siblings, between the need for speed and immediate results offered by local investigation or a potentially more robust response if the skeletal survey is completed at the time of the post mortem examination by more experienced practitioners. The Coroner's Officer was clear both at the time and during the review that a skeletal survey should not be done locally, citing cost as an additional reason for the decision. It would appear that given clear instruction that skeletal surveys should not be done at the local hospital and the professional considerations that support the decision it has become accepted practice that they will never be done locally. A more flexible approach should be adopted that takes into account the safety of other children, the timescale for the post mortem and the availability of suitably qualified and experienced radiology staff.

6.8.7 The protocol recommends that a multiagency meeting is arranged as soon as possible after the sudden unexpected death of a child to ensure that any information known about the child and family is shared with a view to offering appropriate support to the family and, if necessary safeguarding any surviving siblings.

6.8.8 In this case, a police officer worked with the consultant paediatrician who completed the examination after the child's death. Children's Social Care was informed of the death but, due to the time of death, it was not possible for a representative to be present at the initial interagency discussion.

6.8.9 A Strategy meeting was held in the afternoon following the death. The Rapid Response Team were unaware of the death until after the Strategy meeting and therefore not present. The Strategy meeting was unable to determine whether or not the circumstances of the death of C40 were suspicious. It was considered that it would be appropriate for a skeletal survey to be completed to assist in this evaluation. The professionals present at the meeting shared available background information about the family. Little information was presented about the father. The GP, who would have been the only professional with information in records about the father, was neither present nor invited to the meeting. Although GPs may not be able to attend such meetings it must be recognised that they can be a repository of a significant amount of information that may not be accessible to other practitioners and it would be appropriate for them to be asked to make a contribution.

6.8.10 Plans were agreed to support the family, including completion of a core assessment by Children's Social Care. One of the paediatricians present at the meeting consulted with the Coroner's officer and was told that a skeletal survey must not be undertaken locally but would be done as part of the post mortem examination at Great Ormond Street Hospital. This was not challenged further with the Coroner's officer nor was there any direct discussion with the Coroner. The Coroner's officer, when seen as part of the SCR process, indicated that they were unaware of the Child Death Protocol and of the belief that all unexpected deaths would be managed in the same way regardless of age. Practitioners, present at the Strategy meeting, were not aware that this was a policy. Had they been present, a RRT practitioner may have been able to offer advice to the meeting.

6.8.11 In the absence of a clear explanation for the cause of death, paucity of evidence to support any consideration of the death being suspicious and the policy decision to not undertake a skeletal survey, the need to and means of safeguarding the sibling were limited. The need to support all of the family in their bereavement was the main priority of practitioners but, in view of the uncertainty, a plan for the parents to be supervised in their care of C40's sibling was agreed by all and instituted. This was the best that could be done in the circumstances. It was fortunate that there was minimal delay in completion of the initial post-mortem and the subsequent forensic examination which resulted in rapid action to secure the safety of C40's sibling.

## 7 Conclusions and Lessons Learned

7.1 The panel had identified four specific areas for consideration in the review

- To consider if there were any identifiable critical predictors of the event in the parents' background, history and functioning that practitioners could have recognised in their involvement with family members.

- To examine practitioners' understanding and use of thresholds for referrals and access to services.

- To consider the quality and effectiveness of assessments of the parents ability to care for and protect their children

- To examine the effectiveness of the Child Death Overview process to consider and respond appropriately to safeguarding issues of surviving siblings

7.2 The event that resulted in the death of C40 was an act of violence perpetrated by the father. The occurrence and timing of this event was not predictable and practitioners who were providing services to the family at the time were not aware of anything that would have predicted the likelihood of the event or that there was any immediate risk of significant harm to C40 that could have resulted in protective action, such as removing the child. However the analysis of the professional involvement with the family suggests that had professionals responded differently to the family's needs the outcomes may, possibly, have been different.

7.3 There is no reliable predictive framework for fatal child abuse, which is thankfully rare. Reder & Duncan (1999)[34] identified a number of factors that they believed relevant, although they are not a definitive list of risk indicators and are more contributing than determining. The factors are:

- parental history of maltreatment, rejection and/or being in care
- an unresolved conflictual relationship with family-of-origin
- violent relationship between parental couple
- parental mental health and/or substance abuse
- minimal antenatal care
- ambivalence toward pregnancy
- child being attributed with negative meaning

7.4 Although there were some of these indicators in the parents', especially the father's, background they were largely unknown to practitioners. The limited assessments carried out by midwives and health visitors did not elicit the information, the acceptance and normalisation of the level of deprivation and the assumptions made about the family reduced the likelihood of additional information being sought from the GP and their records in which the information was held. The Initial Assessment by the social worker failed to take account of the father and had it done so information available in the Children's Social Care records may have identified risk factors and led to more in depth assessment of the father's parenting abilities.

[34] Reder, P and Duncan, S (1999) *Lost Innocents*, London Routledge

7.5 Whilst the mother, and sometimes the father, was resident with the mother's family there were protective factors and these were taken into account when assessing the needs of the children. The move into their own home did not trigger additional assessment of their parenting capacity without the constant support of other adults, having done so may have identified more of the risks.

7.6 There are indications within the review that thresholds for referrals to other services were known and appropriate referrals made, the concern was more that, when not taken up or followed through, practitioners did not revisit the reason for referral and follow up or escalate continued concerns. This may have been ameliorated by increased management oversight and supervision.

7.7 There were some indications that there were deficiencies in C40's sibling's care, identified by the social worker as the need for additional stimulation. This may have been an indicator of neglect that had not been previously identified by routine health visiting intervention and therefore limited contact. The family assessment did not identify the need for additional support. This was influenced by both the busy caseloads and the low expectations of practitioners working in an area of deprivation.

7.8 As noted throughout the chronology and analysis assessments of the mother's parenting capacity was superficial and father's non-existent.

7.9 Assessments should have resulted in planned interagency action to support the family and a 'team around the child' would have been an appropriate vehicle for this.

7.10 The lack of full examination by the GP of the baby two days before his death was an omission. Assessments of the health and wellbeing of very young, vulnerable babies by health practitioners should include physical examination.

7.11 The Child Death Overview, Rapid Response process is generally well embedded but is reliant on practitioners completing a few key steps and having a full understanding of the implications of their decisions. The lack of early notification of the Rapid Response Team had a knock on effect in this case and a simple process to ensure this happens is essential. A more extensive coverage of the service may also have been beneficial.

7.12 A policy decision, based on expediency for both the Coroner's Office and health professionals, had been made that skeletal surveys would not be undertaken in the hospital; this is contrary to the agreed Child Death Protocol and practice in other hospitals and should be revisited.

7.13 It is well recognised that the perpetrators of fatal child abuse, especially in babies are often fathers or male partners of mothers[35]. A number of initiatives in this country and elsewhere have resulted in public awareness campaigns to educate young men about the fragility of babies and the dangers of shaking.

[35] Kemp A.M. and Coles L. (2003) The role of health professionals in preventing non-accidental head injury. Child Abuse Review 12(6): 374-83.

This often involves engagement of fathers antenatally and immediately post-natally, video and other materials are available[36].

## 8 Recommendations

The health overview, in line with the SCIE Learning Together methodology, identifies a series of questions for the LSCB and health organisations associated with the findings above (Appendix 1). These and the other findings from the reviews of services provided by Devon Children's Services (Appendix 2) and the actions taken after the death have been synthesised into the following recommendations

The SCR was commissioned by Torbay LSCB and is therefore presented to that Board. However as the family were resident in Devon for much of the period under consideration most of the recommendations are directed to both Boards and it may be appropriate for there to be collaboration between the Boards in responding to these recommendations.

8.1 In view of the findings of previous SCRs both locally and nationally that have highlighted the prevalence of a tendency to fail to take full account of fathers when assessing children's needs the LSCBs should develop an awareness raising campaign for practitioners and managers in all agencies. They should use a variety of approaches to ensure the widest possible reach across all practitioners, that includes dissemination of key messages, research findings etc. The use of the Fatherhood Institutes Dad Test[37] may support this activity.

8.2 There should be consideration of a public awareness campaign for parents, especially fathers about the fragility of babies and the dangers of shaking. This could include implementation of the NSPCC's Preventing Non-accidental head injury (NAHI) programme.

8.3 The Boards should require partner agencies to review their standard documentation (written or computer based), including assessment tools and referrals forms, to ensure that relevant information about fathers and other household members is included and that it is updated regularly. The documentation should provide prompts to practitioners about updating and sharing information with other practitioners who are involved in the care of all family members.

8.4 The Boards should work with the Health and Well-being Boards and Clinical Commissioning Groups (the CCG) to pose a challenge to commissioners of services for children and families about the commissioning and funding of services for children and families. This is in line with the outcomes of the Torbay Health and Wellbeing strategy that focus on children having the best start in life, reducing inequalities and recognise the importance of early intervention. Commissioning and funding of services must be sufficiently flexible and targeted to respond to the more intensive needs of areas of disadvantage. Public health

[36] NSPCC's Preventing Non-Accidental Head Injury (NAHI) programme
[37] http://www.fatherhoodinstitute.org/2009/download-a-dad-test-guide/

targets that require specific action by health professionals must take account of clinical priorities and other pressures on health professionals especially in a climate of financial austerity.

8.5 The Boards should ensure that work already undertaken in response to other Serious Case Reviews, multi-agency case audits and inspections is built upon. The Boards should consider the feasibility of the development of agreed standards for supervised structured safeguarding reflection (supervision), in terms of quality and frequency, across the children's workforce that

- are proportionate and appropriate to the role, ways of working, experience and competence;
- challenges assumptions and fixed thinking, promotes curiosity, critical and systematic thinking and the exercising of confident professional judgement
- addresses the emotional impact of working with children and families.

The Boards should develop a competency framework, supported by appropriate training and guidance to ensure that supervisors have the relevant knowledge, skills and attitudes to support this supervision.

8.6 The Boards should regularly seek assurance from the CCGs and other commissioners of health services that contract management arrangements include clear standards for safeguarding, documentation, supervision and inclusion of fathers and wider family members.

8.7 Torbay LSCB should raise with the NHS England Area Team, the relevant professional bodies and Royal Colleges the need for agreed local and national guidance and standards with respect to physical examination of babies and should seek assurance that the Spotting the Sick Child resource has appropriate focus on identification of potential safeguarding concerns.

8.8 Torbay LSCB should seek assurance that the SW Peninsula Child Death Overview Protocols and Procedures are fully embedded in all organisations and that multi-agency training, to include Coroners and their Officers, is a requirement for practitioners involved in their operation. The Board should seek assurance from South Devon Healthcare NHS Trust that the relevant documentation to support the effective operation of the child death process is reviewed to ensure clarity and accuracy.

8.9 The Boards should work with commissioners across the SW Peninsula to consider the feasibility of increasing the availability of the Rapid Response Team to include weekends and nights.

8.10 South Devon Healthcare NHS Trust should review and where necessary revise procedures and documentation in relation to child deaths to ensure immediate notification of the Rapid Response Team. It should also, in collaboration with the Coroner and the Child Death Overview Service Team undertake a review of the access to skeletal surveys.

Appendix 1

## Findings of Health Overview

### Summary of issues for consideration by the TSCB

**Finding 1: Professionals saw mother as a single parent and gave minimal consideration of protective or risk factors of father of the children and the wider family members.**

**Finding 2: Additionally there was an acceptance of both parents' circumstances even though their outcome and the children's were at risk of being poor.**

- Is the Board in a position to ensure that there is a culture of challenge amongst health professionals when not seeking the voice/ experience of the child and considering parenting capacity?
- Is there commitment that the recommendations of WTTSC 2010 to 'think father' be enacted?
- Does the LSCB have systems in place to challenge the H&WB strategy in order to support frontline staff to understand and effectively deliver health and wellbeing outcomes, particularly with respect to safeguarding children?

**Finding 3: Mother was 'suggestible' (appearing to concur with staff advice) and professionals felt they were providing effective help because of this. Work often addressed the symptoms and not the cause, usually following a specific trigger point.**

- Does the Board have assurance that recommendations from C26 are being actioned and learning embedded across health services, with respect to services for adolescents and including impact on the (unborn) baby for those pregnant?

**Finding 4: At times when professionals found themselves concerned and escalating level of input or referring on, this was not communicated to other health professionals involved, so missing the opportunity for wider consideration of progress and clearer risk assessment.**

- Is Board assured that all staff are supported to maintain important communication links (particularly in a period of increased but staggered implementation of electronic facilities)?
- The Threshold Matrix is not embedded in information sharing policy and practice across health. As an example referral forms such as MASH form could prompt staff to notify line manager/ key staff within their own agency.

**Finding 5: When levels of concern met threshold for referral for multiagency review, a lack of response was not challenged. Staff were not consistently familiar with the concept of supervision and of how important it is, in safeguarding, to resolve professional differences. These factors allowed the case to drift.**

- Would the Board concur with the Review Team that an organisation culture of valuing people and openness is essential for effective child safeguarding and have assurance that systems such as encouragement of expression of problems, use of solution based case management and monitoring of use (and effectiveness) of the professional escalation policy are routine within member organisations?
- Supervision is an intervention for the family to prevent escalation and drift – how can the Board support organisations to embed supervision?

**Finding 6: Health and multiagency tools do not consistently capture unborn baby and father/ partner information, which were felt to be useful prompts to necessary assessments.**

**Also there is an absence of prompts to capture 'any change since last contact?' information.**

- Is the Board assured that the multiagency referral form is fit for purpose, to capture all adults and children causing professionals concern around risk?

**Finding 7: This review demonstrated that health management systems have improved in recognising threshold matrix level 4 (child protection) but not level 2 & 3 (child in need).**

**Finding 8: Record keeping standards are not consistently audited with respect to safeguarding and communication systems were found to be hindering safeguarding.**

- Is the Board assured that local commissioning systems and contract monitoring demonstrate transparency and challenge of service development to ensure recognition of the multiagency threshold matrix and early help?
- Is the Board satisfied that local case audit processes (for documentation standards) include consideration of necessary practice to enable safeguarding?
- And that local training and supervision include review of documentation standards?
- Are national IT development programmes sufficiently safeguarding focussed?

Appendix 2

FINDINGS OF DEVON CHILDREN'S SERVICES REVIEW

**FINDING 1:** Father was not seen as part of the family unit, nor was he engaged in the assessment even though it was known he planned to join the family (mother, C40 and C41) when they had their own housing.

- The Dad Test Guide for children's and family services: how to start 'thinking fathers' is available to assist the DSCB and partner organisations to promote a positive culture of engaging with fathers.

**FINDING 2:** The lack of identifying mother, C40 and C41 as a separate unit from the wider family was influenced by the student's previous involvement with the family (during the assessment of uncle).

**FINDING 3:** The kick to mother's stomach from uncle was a safeguarding risk which should have been subject to a pre-birth assessment in more depth than the initial assessment.

- Is the recent focus on risk analysis and decision making sufficient to support safe practice, particularly in respect of pre-birth referrals?

**FINDING 4:** When the outcome of the assessment did not meet the threshold for social work intervention, consideration should have been given to step down in to Early Help missing the opportunity to engage local resources including the children's centre.

**FINDING 5:** The electronic referral record used in the MASH does not lend itself to differentiate between information collected as part of a social history and information about the referred child.

**FINDING 6:** Weak management oversight and supervision is non-challenging and task related, lacking opportunity for reflection.