CITY OF YORK SAFEGUARDING CHILDREN BOARD

Serious Case Review

Baby A

EXECUTIVE SUMMARY

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1. Introduction

This Serious Case Review (SCR) was carried out in accordance with Chapter 8 of Working Together to Safeguard Children 2010. It concerns Baby A who was twenty weeks old when they died. The injuries which led to the death were thought to have been caused non-accidentally, possibly as a result of having been shaken. At the time Baby A was living at home with their mother.

The Serious Cases Review Panel met and concluded that the criteria for undertaking a SCR were met and this was based upon the following:

- That a child had died *and* abuse or neglect was suspected to be a factor in the death.

The purpose of the SCR was to establish whether there were any lessons to be learned from an analysis of this case; to identify those lessons clearly; and to recommend what steps should be taken to improve both single agency and inter-agency working.

The Independent Chair of the Local Safeguarding Children Board is Roger Thompson.

2. Review Process

Serious Case Review Panel:

The Independent Chair of the Serious Case Review Panel was David Radford. Members of the Serious Case Review Panel had no previous involvement with the case under review.

Title	**Agency**
Independent Chair	Independent Consultant
Head of Preventative and Safeguarding Services	City of York Children's Social Care
Head of Safeguarding	Yorkshire Ambulance Service
Designated Doctor for Child Protection	NHS North Yorkshire and York
Designated Nurse, Nurse Consultant for Safeguarding Children.	NHS North Yorkshire and York
Detective Superintendent	North Yorkshire Police
Associate Director	York Teaching Hospital NHS Foundation Trust
Head of Service	Leeds Children and Young

East/North East Leeds	Peoples' Social Care
Operations Manager Leeds	West Yorkshire Probation Trust
Director of Probation, York	York and North Yorkshire Probation Trust
City of York Safeguarding Children Board Manager	City of York Safeguarding Children Board

The Serious Case Review Panel agreed the Terms of Reference for the SCR and met on several occasions during the timescale of the SCR to review progress, discuss involvement of family and receive the Individual Management Reviews

An independent consultant, Ann White was commissioned to write the Serious Case Review Overview Report. She had no previous involvement with this case and is independent of any of the agencies involved.

Individual Management Reviews (IMRs) and chronologies were provided by the following:

- City of York Children's Social Care (YCSC)
- Leeds Children and Young Peoples' Social Care (LCYPSC)
- York Teaching Hospital NHS Foundation Trust (YTHFT)
- North Yorkshire Police
- NHS North Yorkshire and York Primary Care Directorate (GP Services) (NYYPCD)
- North Yorkshire and York Community and Mental Health Services
- Yorkshire Ambulance Service (YAS)
- West Yorkshire Probation Trust
- York and North Yorkshire Probation Trust
- University Hospital of South Manchester NHS Foundation Trust

A report was provided by the following:

- Leeds Teaching Hospitals Trust
- A Health Overview Report was provided by NHS North Yorkshire and York.

None of the IMR authors had any previous involvement with this family.

Issues of ethnicity, religion, language and culture were considered in this review.

Parallel Processes

At the time the SCR was completed, the Police were still investigating the circumstances which led to the death.

Involvement of Family in SCR
It was not possible to interview Baby A's mother for this SCR because of the on-going Police investigation. The Overview Author and Chair of the SCR Panel did meet with Baby A's father and sought his views about the agencies involved with the family (he was not under investigation by the Police in connection with Baby A's death).

3. Summary of the information known to the agencies

1. The IMRs and the Overview Report together provide considerable detail about the agencies' involvement with Baby A and their family. The following is a very brief summary of that involvement.

[Redacted]

The outcome of the Initial Assessment undertaken by Leeds Children and Young Peoples' Social Care was that there should be a Pre-Birth Core Assessment and this was commenced when Mother was about twelve weeks pregnant. This assessment was not concluded by Leeds Children and Young Peoples' Social Care because the couple separated and Baby A's mother returned to live near her family in York. The decision of York Children's Social Care was to undertake another Initial Assessment. There was liaison with the Midwife, Police, **[Redacted]**, one interview of Mother and phone discussion with Father. No GP was contacted in the course of the assessment.

York Children's Social Care was involved with the siblings of Mother and also with the children of Father's siblings.

The outcome of this Initial Assessment was that there should be a Written Agreement with parents, to be monitored by Baby A's Health Visitor **[Redacted]**. There was no direct contact between the Health Visitor and the Social Worker during the course of involvement with the family. The plan, prior to Baby A's birth, was for the case to be closed by Children's Social Care.

Baby A's mother had had considerable involvement with various specialism's in the Health Service prior to becoming pregnant. **[Redacted]**. There were indications in her medical and family history that the Mother's needs were such that she would require additional support in adjusting to being a new single parent.

Baby A was born after only at twenty-seven weeks gestation at a hospital outside of their home area, and after twelve days was transferred back to the Special Care

Baby Unit at the local hospital, remaining there for eleven weeks. Without this specialist medical and nursing care, Baby A would not have survived. While in hospital steady progress in relation to their health needs was made.

The Father visited Baby A on two occasions while in hospital **[Redacted]** Father has a photograph of him holding the Baby A and reports that he changed and fed the baby.

Mother was inconsistent about whether or not Father could have further contact with Baby A and he had no other contact with the baby after these two visits to the Special Care Baby Unit. Baby A was discharged from Hospital, aged thirteen weeks and it is about this time that Mother began a new relationship with another partner. There was very little information available to the SCR about this person.

Involvement with a Neonatal Outreach Sister and Health Visitor commenced when Baby A was discharged from the Special Care Baby Unit. Although the plan was undocumented, it appears that the Neonatal Outreach Sister took the lead and the Health Visitor saw Mother and baby on one occasion from the discharge until the death.

Baby A lived with their Mother in accommodation she had secured while Baby A was in the Special Care Baby Unit. Her new partner was a frequent visitor to the home and on occasions stayed overnight and assisted in caring for the baby. The Neonatal Outreach Sister emphasised to Mother that Baby A was to be her priority, not a new relationship. Given that neither the Initial Assessment nor health professionals had identified any needs in relation to Mother, **[Redacted]**

Baby A was at home for just over six weeks before being admitted to Hospital with injuries which were to prove fatal. In those six weeks, there was close contact by the Neonatal Outreach Sister with the family and she became increasingly concerned that Baby A was not putting on sufficient weight. Baby A was admitted to the Children's Ward on two separate occasions when there were concerns about an infection and weight loss. On both occasions while in Hospital, when fed by hospital staff and when Mother was supported in feeding Baby A at sufficient frequency, Baby A did gain weight but again lost or didn't weight gain on discharge. Prior to the second admission, Mother asked the Neonatal Outreach Sister not to tell Children's Social Care about the weight loss and admission.

Such was the Neonatal Sister's concern about the rate of weight gain that she consulted with two senior medical colleagues who concluded that this should be reviewed again in three days time when Baby A was due to be admitted to hospital for planned surgery. There are some indications that the possibility of Baby A's needs being neglected by their Mother was considered, certainly at the second hospital admission, but this differential diagnosis was not explicitly recorded in Baby A's medical notes.

Three days after that consultation with medical colleagues, Baby A was admitted to hospital in York as an emergency. Baby A required emergency treatment and ventilation to stabilise their condition. Following this Baby A was transferred to the Regional Paediatric Intensive Care Unit in Leeds. The baby's condition deteriorated and Baby A was observed to be fitting, had a swollen brain with subdural bleeding. Retinal haemorrhage was also seen. In the opinion of the Consultant Paediatrician the injuries were non-accidental, possibly due to Baby A having been shaken. A child protection investigation was therefore initiated.

[Redacted]

Intensive care for the baby was withdrawn as there was no prospect of Baby A recovering from the brain injury. Mother, her partner and her father cared for Baby A in hospital until the death, five days after being admitted to hospital. The Post Mortem supported the opinion that the injuries were non-accidental. The Mother and her then partner were arrested on suspicion of Murder and Causing or Allowing the Death of a Child. At the time of writing this Summary, the Police investigation is on-going.

4. Key Findings of the Review

The Serious Case Review Panel concluded that it had not been possible to predict that Baby A would receive such serious injuries. Nevertheless, opportunities were missed which would have identified that Baby A's mother had needs of her own which indicated that she would require additional support in adjusting to being a new parent.

The findings indicate that there are significant lessons to be learnt by all the agencies involved. The most crucial of which are summarised below.

Effective communication and information sharing

There is no evidence that professionals deliberately withheld information from each other in relation to Baby A and the parents. There is though evidence that some professionals did not give any, or sufficient, consideration to the safeguarding significance of the information they held and the manner in which it was shared.

Neither before or after Baby A's birth is there any evidence that any GP considered the safeguarding significance of information relating to the mother's mental health. There is no evidence that consideration was given to whether it should be shared ante-natally with the Midwife and post-natally with the Health Visitor and those health professionals responsible for the care of the baby while in the Special Care Baby Unit and subsequently after discharge home. It is not possible to speculate whether or not, had the pregnancy gone to term, that the Midwife would have accessed the GP records in relation to the mother. In preparation for her involvement, the Health Visitor did not access the mother's GP records.

There were six GP practices in the Medical Group and any one of the twenty-nine GPs could be consulted by a patient. The information sharing processes within the Medical Group did not support any one GP being able to easily gain an overview of the pertinent issues in relation to the Mother or any possible risk factors in her becoming a parent.

Information sharing in the course of the Initial Assessment undertaken by York Children's Social Care was incomplete. The Social Worker assumed that the Midwife would have shared any relevant health issues with them. Consequently no contact was made with the Mother's GP as part of the Initial Assessment and this opportunity for those records to be reviewed was missed. The Midwife was aware that the Mother had been depressed the previous year but this information was not shared with the Social Worker. Neither did the Social Worker enquire further of the Midwife when they learnt from the Mother that she had seizures that she thought the baby's father would attribute to her use of alcohol. The implication of these gaps in information sharing was that the impact of Mother's health and social background upon her parenting capacity was never appropriately taken into consideration by health or social care professionals.

[Redacted]

When any professional is told by a parent not to tell Social Care about something concerning their child's well being, this should be taken very seriously by that professional. The Neonatal Outreach Sister was asked by Mother not to tell Children's Social Care that the baby had lost weight. The comment should have been explored with Mother and discussed with the Hospital Child Protection Team to reach a decision about sharing that information with Children's Social Care.

Assessment Quality

There were no concerns raised in any of the IMRs about the quality of the medical assessment and care which was given to Baby A. Without this specialist care, a baby born at just over 26 week's gestation would not survive. When Baby A was discharged from the Special Care Baby Unit the Neonatal Outreach Sister became involved and Baby A continued to receive close medical oversight of their development.

There was though a predominately medical model of care evident in the hospital's involvement with Baby A. The IMRs evidenced that the valuable observations the staff in the Special Care Baby Unit about how the mother and baby relationship was developing, were not fully appreciated. Although nursing staff did support mother in how to attend to the baby's medical needs, there was not sufficient detail recorded about any developing attachment between the Mother and baby or Mother's demeanour. These, if recorded, could have contributed to a more holistic assessment of the family's needs and contributed to the understanding of the development of attachment between mother and baby.

After discharge, the focus of the Neonatal Outreach Sister was Baby A's medical needs. The fact that her involvement took precedence over the involvement of the Health Visitor meant that this opportunity for there to be a more holistic assessment was missed.

A Pre-Birth Core Assessment had commenced prior to Baby A's parents separating but only an Initial Assessment was undertaken by York Children's Social Care when the mother returned to her home Local Authority. There was one visit to the mother but father was not seen in the course of the assessment.

Not all sources of information were accessed during the Initial Assessment, in particular the GP's records. There was no consideration given to sharing the written assessment with professionals who were to have on-going involvement with the family. Despite the Health Visitor being named as the person to monitor the written agreement, this was never discussed with her by Children's Social Care.

The decision by Children's Social Care not to undertake a more detailed holistic assessment was a missed opportunity and was based upon the fact that the parents were no longer co-habiting, although they were in touch with one another and Father wanted to have on-going contact with his baby. There was no exploration and analysis of mother's views about the ending of her relationship with the father of her baby or the nature of any ongoing relationship between the parents. The implications of this were that Mother's own needs and the possible impact they could have upon her parenting capacity **[Redacted]** with Baby A, remained un-assessed.

This influenced how other professionals understood the family context in that there was an assumption that there had been a detailed assessment by Children's Social Care. **[Redacted]**. The consistent message to other professionals was that the case would be closed by Children's Social Care.

The system which existed in York at the time for carrying out Initial Assessments did not lend itself, once the decision to close has been made, to the consideration of new information unless it in itself would warrant a re-referral to Children's Social Care. This meant that new information, from before Baby A's birth but after the Initial Assessment had finished, remained un-evaluated. Opportunities to re-consider the initial judgement and plan were therefore missed.

Risk Assessments

There is no evidence that assessment of any risks to Baby A was adequately undertaken by York Children's Social Care. That risk assessment was one-dimensional in that it focused on factors in relation to the baby's father to the exclusion of any adequate exploration of the Mother's health and social history or adequate consideration of the dynamics of the couple's relationship, wider family and friend influences on the parents and the impact of Baby A's birth on the

parents. The plan to manage the risk (by a Written Agreement with parents) was therefore based upon incomplete evaluation of all the relevant areas.

There was no evidence of there being adequate guidance to professionals about how to assess and manage the risk.

[Redacted]. There was no attempt to incorporate the inevitably new information about the development of a relationship between Mother and Baby A, after the birth, into a revised risk assessment. The valuable contribution Special Care Baby Unit staff could have made to this by sharing their observations with Children's Social Care was not given or sought. The fact that Baby A was born pre-term should have alerted both Social Care and health care staff to the risks of disrupted attachment and indicated a need to review the existing plan. **[Redacted]**.

Written agreements with parents

[Redacted] Such an agreement is with the Local Authority yet York Children's Social Care closed the case and was to play no part in monitoring it. The Health Visitor was named as the professional who would monitor compliance with the Written Agreement but she was unaware of its existence. There was no plan for the Written Agreement to be reviewed as the family circumstances changed and developed.

Multi-agency work and multi-disciplinary work

The evidence from the IMRs is that staff from York Children's Social Care, York Hospital staff, the Health Visitor and GPs who were working with the Mother and Baby A did not consider how they could effectively work together in a holistic manner, to support this family and protect Baby A.

York Children's Social Care did not seek full information from agencies both before and after Baby A's birth (for example: from the GP, not following up with the Special Care Baby Unit about the quality of parents' contact with the baby, and not contacting the Health Visitor). **[Redacted]**. This suggests that the work was not based upon sound inter-agency team work.

The practice demonstrated by Special Care Baby Unit staff, Midwife, Neonatal Outreach Sister and Health Visitor indicates that they did not sufficiently see themselves as working as a team, either within health services alone, or in partnership with Children's Social Care.

There was no Discharge Meeting to plan for Baby A's discharge from the Special Care Baby Unit. It has been hypothesised that this may not have been considered by Hospital staff because there had been no previous multi-agency meeting in this case. Given that prior to the discharge, Special Care Baby Unit staff were under the impression that the case was still active to Children's Social Care, it would have been best practice had the Hospital initiated such a meeting to ensure that all the

professionals who would be involved in the care in the community were clear about their respective roles in supporting the family.

There was not sufficient understanding of respective professional roles in relation to the assessment of need and risk in this case. The contribution each professional had to make to the whole safeguarding picture was not adequately recognised.

Planning

To ensure that all relevant professionals are involved in a Pre-Birth Assessment, a written plan should be in place. Leeds Children and Young People's Social Care require this but one was not in existence for this case. It would also have been required had York Children's Social Care undertaken a Pre-Birth Core Assessment.

The plan about Father's contact with Baby A being subject to a Written Agreement was not adequately conveyed to all the professionals who required this information.

There was no written plan between the Health Visitor and the Neonatal Outreach Sister detailing their respective roles and involvement with the family. This omission contributed to there being an emphasis on meeting Baby A's medical needs at the expense of involving the Health Visitor in assessing their more holistic needs. Also It would not have been possible for any other Health Visitor to know what the Health Visiting plan was.

Supervision

It is imperative that there is adequate time for Social Workers and managers to reflect upon their work, judgements and decision making about cases. In this case there is no evidence provided that supervision of the Social Worker promoted reflection. Had it done so, issues in relation to risk assessment, feasibility of the Written Agreement and the need to revise initial judgements should have been identified.

Reflective Child Protection Supervision, with Special Care Baby Unit staff and the Neonatal Outreach Sister in particular, does not appear to be established. Had it been, it may have prompted those staff to 'reflect in action' and as a result have different strategies to support Baby A's mother. Consequently there may have been an increase in 'healthy scepticism', and a readiness to challenge both the mother and other professionals.

Impact of organisational factors

At the time of their involvement with this family, Social Workers in the Referral and Assessment Team in York were working with caseloads which were too high. It has been hypothesised that this had a negative impact upon the quality of the work of the practitioner and their manager in this case.

The Health Visitors attached to the Medical Group involved in this case are not managed or supervised in the same way as others in the city. This SCR has highlighted the need to make changes to remedy this situation to ensure that best practice is the norm. For instance, that in the future they receive reflective child protection supervision and that their record keeping, planning and inter-agency work is improved. It would also support their professional development if they were managed and supervised in line with other Health Visitors in the area.

Recording and the use of records

There is still reluctance on the part of nursing staff, despite this area being addressed in training, to record their observations about a parent which may be considered 'judgemental' rather than a record of a professional judgement.

When asked by Children's Social Care to record observations of the Father's visit to Baby A when in the Special Care Baby Unit, this was not done by hospital staff. Potentially relevant information about the relationship between the parents, how the Mother was able to supervise contact and the nature of the Father's interaction with Baby A was therefore lost.

When Medical and Nursing staff were considering the possibility that mother may not be feeding Baby A adequately, this differential diagnosis was implicit rather than being stated in the baby's records.

It is important that family relationships are accurately described in records. For instance, it was often assumed by Hospital staff that mother's partner was Baby A's father and his actual father was sometimes referred to as 'Mum's partner.'

There was not an accurate record by York Children's Social Care of what searches had been undertaken in relation to any previous involvement they may have had with the family in question. This should have included whether the Adult Services data base had been interrogated. When interviewed in connection with this case, the Social Worker could not recall whether all three previous referrals had been seen and there was some significant information in relation to mother which was held in Adult Services' records.

Maternity records are not routinely accessed by the Special Care Baby Unit and there is the potential for significant information about the parent to remain unknown to those who are caring for premature babies. In this case the Midwife should have alerted them to the involvement of Children's Social Care and later sent a copy of the Written Agreement to the Unit. There is also no indication that the Special Care Baby Unit was aware that Baby A's Mother had been depressed during the previous year. This was information which could have implications for the mother-baby relationship and therefore would be useful information for the Special Care Baby Unit and the Neonatal Outreach Sister to have.

There were examples of agencies not recording information in relation to ethnicity, religion, language and, where relevant to the particular agency's role, any other contextual cultural information about the family (e.g. employment, family structure).

5. Examples of good practice

The IMRs demonstrate several areas of good practice and the following are some of the examples.

- **[Redacted]**
- It was good practice that Leeds Children and Young Peoples' Service commenced the Pre-Birth Assessment very promptly, even though it was very early in the pregnancy.
- The use of some of the Scales and Questionnaires recommended by The Framework for the Assessment of Children In Need and their Families (DOH 2000) as part of the Pre-Birth Assessment is good practice.
- The Epilepsy Specialist Nurse demonstrated her ability to think outside of her own particular remit and recognised that the Mother (prior to her pregnancy) would benefit from a referral to Psychological Services.
- The Neonatal Outreach Sister was tenacious in following up her concerns about Baby A's weight loss with medical colleagues.
- **[Redacted]**

6. Conclusions

- If the GP, Midwife and Health Visitor had reviewed the information held in the GP records about Mother they should have concluded that there were some pertinent issues in relation to how she herself had been parented, her mental health and coping strategies which could impact upon her parenting of a child. Such a review would have alerted the hospital nursing and medical staff, the GP, the Midwife, the Neonatal Outreach Sister and the Health Visitor to the possibility Baby A's Mother could experience difficulties in adjusting to parenthood. They could then have planned their intervention and support accordingly to meet her needs as a single parent of a pre-term baby.
- **[Redacted]**

- **[Redacted]** The absence of such a holistic multi-agency assessment and plan meant that any safeguarding attention was superficially focused **[Redacted]** Information about Mother's needs was never identified **[Redacted]**

- This one dimensional approach to a risk assessment prevented any observations of Mother and her situation and behaviour being considered within a safeguarding framework. It set the tone for Social Care's, Probation's and Health Services' involvement with this family.

- Had information sharing and assessment been thorough, a different level of support may have been offered to Mother. Crucially there then may have been a different professional response when Baby A was losing and then not putting on weight as expected when at home, and when Mother began her new relationship.

- **[Redacted]**.

7. Recommendations from the Overview Report

These recommendations are made having taken into account the recommendations made by individual agencies, the progress made with the recommendations arising from previous SCRs and the changes already made by York Children's Social Care to the Referral and Assessment Team.

Recommendation 1

City of York Safeguarding Children Board should review what frameworks for risk assessments are currently in use and agree an operational framework for conducting risk assessments. The framework should be based on the Framework for the Assessment of Children in Need and their Families to ensure that all information in the three domains has been considered. As a minimum, a risk assessment framework should include the following:

- A definition of the circumstances in which risk assessment (as opposed to generic assessment) should be undertaken,

- Clarity about factors which constitute risk and the components of risk,

- A focus on longer term risks as well as immediate risk of harm,

- A focus on strengths and protective mechanisms as well as weaknesses,

- A framework for the analysis of information gathered.

Intended Outcomes

- Assessments are based on a shared multi-agency understanding of the definition and components of risk.

- Decision making about whether a child is safe and planning for the child and family are informed by a clearer understanding of risks and needs, based on 'analytical' rather than 'descriptive' assessment.

- Decision making is informed by analysis of the likelihood of future harm as well as immediate risk of harm.

- Outcomes for children are clearly identified.

Recommendation 2

City of York Safeguarding Children Board should include monitoring of the use of the agreed risk assessment framework, and measures of its impact in their quality assurance programmes.

Recommendation 3

City of York Safeguarding Children Board should require that a multi-agency pathway should be developed in respect of actions to be taken by professionals where there are safeguarding concerns in relation to the unborn baby. This should include:

- Actions for all professionals likely to be involved with the children and their families.

- Actions to be taken should the baby be born pre-term.

- Actions when the baby is born somewhere other than where the birth was planned.

This should then underpin the revision of the Procedures and Guidance in relation to unborn babies which is one of the recommendations from YCSC. It will also contribute to multi-agency training and development

Intended outcomes

Professionals involved with unborn babies where there are safeguarding concerns will have a shared understanding of their respective roles and responsibilities.

[Redacted]

Recommendation 5

City of York Children's Social Care should develop measures which will assist them in understanding the impact of their recent investment in improving and developing the quality of social work supervision. This should include, for instance: views of

supervisors and supervisees; quality of the record of supervision, including that on the case record; models other than one to one supervision being used; evaluation of the balance between reflective and managerial supervision.

Recommendation 6

City of York Children's Social Care, on the completion of an Initial Assessment, should consider whether and how it should be shared with contributing Professionals. Even though other professionals will have contributed information and therefore need to know the outcome of the assessment, it would not be necessary to share the written document in every case. The decision made should be included on the Initial Assessment document. This should be an item to be included in their revised Audit and Evaluation Framework.

Intended Outcome

Professionals contributing to the assessment, or those expected to remain involved, will be fully informed about the assessment's outcome and any implications for their future involvement with the child and their family.

Recommendation 7

City of York Children's Social Care should revise their procedures to include a requirement that when there is a decision, during the course of a child protection investigation to refuse a parent contact with a child, that initial decision should remain under review as more information about the child and family's circumstances becomes known to the professionals during the investigation.