

# **Coventry Safeguarding Children Board**

## **Serious Case Review**

### **Baby F**

Date of serious incident: September 2015

Date of report: 1<sup>st</sup> May 2016

Agreed by Coventry Safeguarding Children Board: 24th May 2016

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## **1. Summary of the case**

- 1.1 The subject of this serious case review (SCR) is Baby F, a four week-old baby boy who was admitted as an emergency to University Hospitals Coventry & Warwickshire (UHCW) NHS Trust with a serious and life threatening intracranial bleed in September 2015. He was resuscitated by senior medical and nursing staff. Following a head scan, the consultant leading his care reported this serious non-accidental head injury to the police and children's social care.
- 1.2 Baby F requires continuous care and is being looked after by foster parents.
- 1.3 This case is still subject to police proceedings and the overview report that follows is therefore based on analysis of evidence provided by most but not all of the professional staff involved with the family of Baby F. Once the criminal proceedings are concluded, an addendum to this report will be produced, if appropriate.
- 1.4 The family of Baby F were known to children's social care. The mother had been in contact with services sporadically since 2008.
- 1.5 The focus of this review is Baby F and the non-accidental injuries sustained by him. However, the scope of this review includes a focus on parenting within this family. In particular, the review considers the parenting of an older half sibling, Child V and the risk factors and concerns raised about the family prior to Baby F's birth, with an emphasis on understanding how agencies worked together and how the context of those agencies may have affected the work of their practitioners.

## **2. Terms of Reference**

- 2.1 The terms of reference for the serious case review are as follows:
- How did services respond to various incidents that arose during the specified period? Was this appropriate?
  - Is there any evidence from the siblings or any other source that the parents posed a risk?
  - Did Services engage effectively with the family and identify subsequent risks and interventions?
- 2.2 The panels was made up of senior safeguarding representatives from the following agencies:
- West Midlands Police  
University Hospital Coventry and Warwickshire  
Coventry and Warwickshire Partnership Trust  
Coventry and Rugby Clinical Commissioning Group  
Coventry City Council Children's Services  
Legal advisor to the Panel
- 2.3 It was agreed that the scope of the review would be a period of three years from 2012 when concerns were raised with children's social care about Baby F's older half

sibling, Child V, until September 2015 when Baby F sustained his head injuries. The SCR panel agreed that the history of Child V was also crucial in order to learn lessons for future practice.

- 2.4 In addition, the SCR panel requested that the reviewers consider recommendations from recent reviews, namely the importance of the voice of the child within professional practice.

### **3. The Process**

- 3.1 The LSCB's serious case review sub-committee met in October 2015 to consider the circumstances of Baby F's injuries. It was recommended that the case met the threshold for a serious case review because of the serious harm to the child and the need to establish the way in which the authority and their Board partners worked together to safeguard him.
- 3.2 The parents of Baby F were arrested following the incident and were on bail during the period of the serious case review. The immediate family of Baby F therefore did not contribute to the SCR process.
- 3.3 Individual agency reports (IARs) and chronologies were sought from the five agencies involved with the family and the reviewers then conducted conversations with relevant practitioners. The SCR sought to understand practice from the viewpoint of the practitioners who were involved with the family of Baby F rather than using hindsight.
- 3.4 The independent reviewer presented the consolidated evidence, the key themes and lines of enquiry to the SCR panel for discussion and challenge. The subsequent evidence and analysis were shared at a practitioner event prior to completion of the final overview report.

### **4. Background prior to the scoped period**

**Table of family members within the scope of this review**

<b>Baby F</b>	Non-accidental brain injury sustained at less than 4 weeks old (Sept 2015)
<b>Relationship to child subject within the review</b>	<b>Age at start of the review</b>
Mother (R)	31
Father (J)	29
Half sibling 1 (Child G)	11
Half sibling 2 (Child V)	8
Father of half sibling 2 (W)	unknown

- 4.1 The mother of Baby F became known to children's social care in 2008 in a key episode which lies outside the agreed timeframe for this review but which is an

important early indicator of her parenting skills and her future relationship with Baby F's older half sibling.

### **Key Episode 1: Mother's parenting skills**

- 4.2 In July 2008, at nine months old, Baby F's older half sibling, Child V, was admitted to hospital for 'failure to thrive' (now known as 'faltering growth') but no medical cause was found. The child was referred by the health visitor (HV) who had been asked by the GP to arrange a visit to the family and to insist on the baby's admission. The GP and health visitor were concerned that Child V was not gaining weight appropriately or reaching the expected developmental milestones.
- 4.3 After receiving a normal diet in hospital, Child V rapidly gained weight. Mother was educated in how to adequately feed her child during her admission. The hospital contacted the Referral and Assessment Service (RAS) in children's social care and a social worker was invited to attend a meeting of professionals. Mother consented to social care being contacted.
- 4.4 Prior to Child V's discharge from hospital, a discharge planning meeting took place to ensure that information was appropriately shared across the relevant agencies. This resulted in a health visitor led Common Assessment Framework (CAF)<sup>1</sup> and agreement that there would be a referral to children's social care if the proposed fortnightly HV appointments were not kept or if there was any weight loss.
- 4.5 Child V was eventually discharged from paediatric follow-up in March 2009 having continued to gain weight and to make good developmental progress.

### **Analysis**

- 4.6 This episode provides evidence of an early concern regarding the mother's parenting skills and her ability to feed and nurture her child. One possible cause is wilful neglect however in this case, the support and advice provided for the mother enabled her to respond effectively to her child's needs. The consultant paediatrician worked with social care and a joint decision was made to provide increased health visitor support and a health visitor led CAF, which proved effective.
- 4.7 Almost seven years later in 2015 when the mother was pregnant with Baby F, this previous medical information regarding concerns about the mother's parenting skills was not known to the midwife who undertook the initial booking assessment nor to the health visitor who undertook a targeted antenatal visit in the 3<sup>rd</sup> trimester. The child's record had been passed on to the school nursing service as Child V was by then of school age.
- 4.8 For the midwifery service however, this information would become known soon after the initial booking assessment as it would be part of the GP record used by the midwife undertaking the mother's antenatal care.

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<sup>1</sup> **CAF:** The CAF (Common Assessment Framework) is a shared assessment and planning framework used by children's services when it is felt that a child has additional needs. It is set up to identify those needs and coordinate relevant services.

- 4.9 It is recommended practice that GP practices hold regular multi-agency meetings at the surgery in order to share relevant information with professionals working with vulnerable patients. However, at the time of this review, the family's GP surgery did not hold regular structured face to face safeguarding meetings involving the midwifery and health visiting teams. The practice nurse has some time to support vulnerable families and link to this team but contact with GPs is opportunistic, with support offered when an issue arises.
- 4.10 Currently, CWPT are implementing an electronic system of notes within health visiting. This will allow for easy access to family records for the health visiting service. If there are any concerns regarding a child or family, the HV will be required to make contact with the relevant school nurse to establish if there have been or are any concerns in respect of any siblings.

## **5. Professional involvement with Baby F's mother and half siblings**

### **The Family GP**

- 5.1 Throughout the three year scoped period of this review, Baby F's mother and half siblings were registered with a GP practice. At the time of his injuries in September 2015, Baby F was in the normal process of being registered with the family GP but at less than four weeks old documents, including the birth certificate, were awaited in order to enable full registration. He had access to healthcare at the GP practice if required.
- 5.2 The mother has a previous history of anxiety and depression and had been offered counselling and anti-depressants by her GP. The mother had presented to the GP on several occasions with concerns about the behaviour of Child V and her failure to cope with her child. Over the course of an 18 month period when Child V's parents were in dispute about custody and involved in court proceedings, the mother was diagnosed with anxiety and depression. The cause was noted as the stress with her former partner and Child V's poor behaviour.
- 5.3 In April 2012, the GP referred Child V to Child & Adolescent Mental Health Services (CAMHS) but his initial referral was diverted in the assessment phase from a request for assessment to a positive parenting course. Child V's case was seen as a behavioural rather than a mental health issue since the GP's referral letter mentioned Child V's behaviour rather than any concern about a mental health issue. This may account for the initial response from CAMHS.
- 5.4 In 2012, the mother also self-referred to children's social care because she found Child V's behaviour challenging and was concerned her child may be autistic. The social worker's view was that the child's behaviour was normal for the age and stage of development but that the mother's management of misdemeanours was overly confrontational. A CAF was offered to the family but refused.
- 5.5 In late 2012, the GP referred the mother to Improving Access to Psychological Therapies (IAPT) as she had a two year history of symptoms and a recurrence

from five years previously. Assessments of need were undertaken and relevant support offered. The cause of the mother's depression is recorded by her GP as having an autistic child although her anxiety and low moods go back further than Child V's behavioural issues.

### **Mental health services**

- 5.6 The GP continued to make referrals to CAMHS during 2013 as mother had growing concerns about her child's behaviour. In July 2013, a referral by Child V's school to CAMHS was acted on and an assessment took place eight months later, in March 2014. Appointments for autistic spectrum disorder (ASD) diagnosis in the Trust currently take up to a year and so this assessment took place within the expected time frame.
- 5.7 From this assessment, Child V was diagnosed with ASD. The consultant clinical psychologist reported that Child V 'wouldn't talk' at the assessment session although she tried to get the child to speak. According to the clinical psychologist, 'nothing stands out in this case' and 'there was nothing unusual in the accounts people gave of the child's behaviour'. The clinical psychologist was not aware of the mother's background history or her mental health issues at the time that she was assessing Child V.
- 5.8 The mother sought advice and was invited to a 'managing angry behaviour' course but failed to attend on two occasions. Her non-attendance was followed up but she did not engage well with CAMHS regarding her child's behaviour.
- 5.9 Child V's father (mother's former partner) was not involved in the ASD assessment and queried this diagnosis. He reported that Child V's behaviour at his home was normal, responding to sanctions appropriately although he did agree that the child lacked empathy.

### **The Primary School**

- 5.10 Child V had been the subject of a CAF while attending nursery and this was handed on to the primary school in September 2012. At the time of the child's transition into primary school, concerns were raised by the nursery about the child's behaviour and ability to adapt to change. Child V was described as a 'selective mute' by the nursery.
- 5.11 According to the school, Child V 'settled into the class very well' although concerns were raised about the child's behaviour i.e. 'would not share and would hurt other children'. In some situations, Child V 'would stare adults out rather than communicate'. However, as time progressed Child V was able to engage with adults and children and the transition from nursery to school was described as 'good' by the school. The school's CAF Coordinator led on this work with a focus on parenting needs and the mother's difficulties in coping with her child's behaviour.
- 5.12 The school made a referral to the family support worker (FSW) who gradually built a relationship with the mother. Together they discussed her difficult relationship with Child V and the FSW encouraged the mother to see her GP about her anxiety and

depression. The FSW was concerned about the mother's differential treatment of her two children and her apparent lack of attachment to Child V.

## **Key Episode 2: Primary school referral of Child V to children's social care**

- 5.13 On 14 May 2013, the school's FSW made a referral to children's social care because Child V's father reported that he had observed bruises, which he thought were finger marks on his child's arm, during a contact visit with him the previous weekend.
- 5.14 The referral was allocated to a social worker (SW) in the Referral and Assessment Service (RAS). Following discussion with a team manager, she undertook a joint home visit with the FSW to meet with the mother on 15 May 2013. They were concerned about conditions in the flat; a strong smell of urine as Child V reportedly 'wet the bed nightly'. On checking the children's bedroom, it was noted that on one side (for the older half sibling, (Child G) there was a 'lovely made up bed' but on the other side there was just a mattress and a few fleecy blankets on which Child V slept. Mother gave 'lots of excuses' for this, particularly Child V's bed wetting.
- 5.15 It was made clear to the mother that this provision was not acceptable. The FSW had previously allocated money to the family (through the CAF) to provide new bedding for the children. The SW gave the mother two days to get a new bed for Child V. When the SW visited again a new bed had been delivered. As a result of her first visit, the SW reported that an initial assessment was required.
- 5.16 The SW was very new in her first post as a social worker at that time. She subsequently met with Child V but she was not able to recall whether this meeting took place at school or at home and the children's social care file does not make this clear. She reported that Child V would not talk with her. No marks or bruises were seen by the social worker.
- 5.17 Following a strategy meeting attended by representatives from health, Child V's school and the nursery school, the SW became the Lead Professional for the family. The FSW reported that she was told 'quite clearly to stop working with the family' at the strategy meeting. She was not happy about this decision and felt excluded from the ongoing support for this family. It was acknowledged that it may not have been made sufficiently clear to the FSW that as this case was now a child protection issue, the social worker would be the Lead Professional.
- 5.18 The SW conducted the initial assessment and noted the different ways in which the mother treated her two children, Baby F's older half siblings. Mother did not respond well to challenges from the SW, confiding instead in her FSW. She disclosed to the FSW that the father of Child V, her former partner, had been abusive throughout their relationship.
- 5.19 During this assessment process, the father of Child V went back to court to obtain more contact with his child. The SW described him as 'concerned' about his child. In



total, the SW worked with the family for about a year and during that time developed a relationship with Child V who then started to relax with her and speak.

5.20 In June 2013, the school made another referral to the FSW. This was due to the lack of engagement between children's social care and the family. The head teacher was concerned about the children during the summer period if other agencies were not sufficiently involved with the family. As a result, the FSW worked closely with the family during the summer to ensure they had enough food. She reported that mother's moods seemed to improve as did her relationship with Child V during this time. The FSW eventually concluded her work with the family.

5.21 The outcome of the initial assessment in May 2013 was 'No Further Action' but the file was still open to RAS in August when management oversight recommended a CAF. However, in September 2013 this was changed to child in need (CiN) and transferred to the neighbourhood due to 'ongoing concerns about Child V in the care of the mother'.

5.22 In October 2013, there were a number of referrals by the school. All were investigated and appeared to have no substance. A transfer summary was completed in December 2013 but the family case remained open in RAS. Children's social care (CSC) reported for this review that it is difficult from the records 'to determine the perceived level of concern about Child V and whether or how that perception changed or whether it simply drifted in the referral and assessment service'.

### **The Police**

5.23 On 16 May 2013, the Child Abuse Investigation Unit (CAIU) within the Public Protection Unit of West Midlands Police received a referral (see above paragraph 5.14) from children's social care (made by the school to CSC) with concerns regarding the conditions of the mother's flat and the sleeping arrangements for Child V. This referral was recorded on a child abuse (CA) non-crime number (i.e. when a third party referral discloses a vulnerable victim but where no police offences are disclosed) and referred on to the duty detective sergeant for review.

5.24 A strategy discussion took place later that day between the detective sergeant and the social worker in which it was recognised that although the state of the home was of concern it did not fall within the definition of criminal neglect. (The Children and Young Person's Act 1933 i.e. neglected 'in a manner likely to cause injury to health' as a result of failure to 'provide adequate food, clothing, medical aid or lodging'.) It was agreed that the investigation continue as a single agency CSC led enquiry with a view to an initial assessment being completed. Prior to this decision being taken, appropriate intelligence checks on the mother and her address were undertaken by the police. It was established that there were no historical concerns and this information was shared with the social worker and papers filed pending any further contact from CSC. This was effective practice that met the expected standards.

### **Analysis**

- 5.25 The referral to CSC in mid- May 2013 was appropriate and dealt with promptly but CSC report that it is not possible to follow the child's journey thereafter 'due to inadequate reporting'. The CSC agency report for the review acknowledges that record keeping within the service during this period was 'very poor'.
- 5.26 Private family proceedings in relation to contact issues were initiated and CSC directed to provide a section 7 (CA 1989) report. The school was asked to report any injuries promptly to CSC. The Integrated Children's System (ICS) file indicates a number of references to injuries and bruising reported by the mother and by the school during this period but poor recording means that it is difficult to understand the seriousness of the injuries or the dynamics between parents. There is only one record of Child V being seen in school by a duty worker in this period. According to CSC, 'neither the voice of Child V, nor that of Child G, are evident' from the records.
- 5.27 Child V was open to CSC on a child in need (CiN) plan from May 2013 – April 2014 and two home visits are recorded (24 hours apart following the first incident above). Child V was seen twice and that was in school (in May and October 2013 for separate incidents and by different workers). No CiN meetings are recorded.
- 5.28 Following a referral by Child V's school on 23 May 2013 concerning an unexplained injury to the child's hand, Child V's social worker contacted the CAIU. Child V had explained to a member of staff the injury was the result of a bee sting. The SW and police officer from the CAIU discussed and agreed that the SW would visit the school to assess Child V's injury and, if appropriate, arrange for a child protection medical. This took place the following day but no outcome is recorded. There are also numerous recorded telephone messages from the school and parents but no records of calls being returned.
- 5.29 Record keeping within the West Midlands Police Child Abuse Investigation Unit (CAIU) provides further important information. On 28 May 2013, the social worker provided an update for the police. She reported that she had visited Child V in school on the day that the referral was made to CAIU. Child V told the social worker the hand injury was a 'bee sting'. The child protection medical was inconclusive with the paediatrician concluding that the injury could have been caused in a number of ways, including a bite.
- 5.30 The inter-agency working between CSC and the CAIU regarding these two referrals from Child V's school met expected standards. However, the first referral to the CAIU (paragraph 5.23) focused on the state of Child V's home and sleeping conditions and did not include the father's concern about potential bruising on the child's arm. In the case of the second referral (paragraph 5.28) where Child V had another concerning injury, and had the unexplained bruising (paragraph 5.23) been communicated to police, it would have been good practice in these circumstances for a joint police/social care visit to the child and to the child's mother.
- 5.31 On 21 June 2013, the police contacted CSC for an update on the outcome of the strategy meeting where the decision was made to progress to a section 17 child in need core assessment. CSC reported that the mother had been working with CSC

and they were pleased with the progress she had made. Given this progress, CSC felt the case did not warrant a section 47 enquiry with a view to an Initial Child Protection Conference. The case was accordingly filed by the CAIU unless and until any other concerns were raised.

5.32 CSC 'management oversight' in November 2013 records that Child V had bruising to her cheek and eye and that she said (to whom is not recorded) she did it whilst playing. There is no record that Child V was seen by a social worker or that either parent was spoken to. CiN meetings were held and further injuries investigated but they have not been recorded. According to the CSC agency report, the chronology was not sufficiently detailed.

5.33 The school also expressed concerns that minutes of meetings between agencies were not shared with them and therefore staff were not aware of any actions or outcomes for this family. Indeed, it was not until 28 April 2014 when the school contacted CSC again about the family that they were informed that the case had been closed. (The family file was closed following a paper review by a manager in April 2014.) The school's view was that there was still work to do with this family and yet there had been no information or handover for them. Inter-agency working between CSC and the school appears to have been weak during this period.

5.34 It should be noted that this review covers a period when the RAS team was struggling to transfer cases to the neighbourhoods and caseloads were considered unreasonably high i.e between 30 and 50 cases. Staff were working on a three week cycle and SWs were getting up to 15 new cases each cycle making it very difficult to manage long term cases. Since that time, additional funding has enabled the recruitment of more social workers and the average case load is now about 20.

5.35 In addition, an external review of the Multi-Agency Safeguarding Hub (MASH) in late 2015 has led to further changes in practice with this team vetting initial calls and undertaking all the necessary background checks for any referrals.

5.36 The CSC agency report acknowledges that a child's record should clearly identify professional concerns, the response of parents to those concerns, the child's wishes and feelings and a clear analysis of the outcomes or actions necessary to ameliorate risk or to ensure that the child's needs are being met. This approach clearly did not operate during the period under review. However, the attached social worker was able subsequently to describe her ongoing involvement with Child V during this period but she acknowledged that the lack of detailed recording means that their relationship is not fully captured in the child's record.

5.37 Child V's social worker described being 'overwhelmed with things at that time – not progressing things so well' as a result of her workload. It was acknowledged by a RAS manager that cases at that time were held for a very long time and as a result the status of a case was not always clear to the family or other professionals working with them, as in the case of the FSW. Interviews with RAS staff however indicate that practice is different today. The social worker described how this case would be treated today i.e. a single Child & Family assessment would be undertaken within 45

days and a CiN meeting arranged if necessary. The case would then either continue as a CiN case, be stepped down to early help or go to a section 47 enquiry.

## **6. Antenatal period and postnatal period**

### **Key Episode 3: antenatal care**

- 6.1 Baby F's mother, R, booked for antenatal care around 12 weeks into her third pregnancy in late January 2015. She attended the booking appointment with J who she said was her new partner and father of her unborn baby (not the father of her two older children). She described him as her next of kin.
- 6.2 Her booking assessment was carried out by a midwife covering for another colleague who was on annual leave at that time. This booking appointment is a detailed process and includes questions about the mother's past history and the completion of a mental health questionnaire. This questionnaire was important because mother reported problems with low mood and anxiety and that she had been on anti-depressant medication in the past. The mother responded positively to the question on whether she felt she might want support for her mental health issues. She also reported that her mood was currently 'well controlled' and was aware of the need to contact her GP if she needed further support.
- 6.3 It is normal practice for the mental health questionnaire to be faxed to the perinatal mental health team for referral for further assessment. It has not been possible to ascertain from the mother's patient record if this form was received, whether it met the threshold for intervention nor any response to it.
- 6.4 The midwife described the mother as 'quite honest and open about her involvement with social care'. She referred to her social worker and the occasion when the school reported bruising on Child V's arms. She said that her daughter had behavioural problems and disclosed her ASD diagnosis.
- 6.5 As a result, the midwife completed a social care referral form in order to request further information from children's social care about their involvement with the family and to inform CSC that mother was pregnant. This was not a referral with new concerns about a child but is the standard and currently accepted way of information sharing between health professionals and social care when requesting information.
- 6.6 A social worker in the multi-agency safeguarding hub (MASH) received the faxed referral from the midwife regarding the mother's disclosure of previous social care involvement. She rightly considered this a request for information (and not a referral) and rang to speak with the midwife. She reported that the last involvement with the family was May 2013 and that the case was closed. They discussed the new father and the SW looked on the system to see if there were any reported concerns about him. She shared what she believed to be 'relevant, proportionate information' with the midwife i.e. the reasons why CSC had been involved with the family, in accordance with guidance on information sharing used within CSC at that time.

- 6.7 The midwife did not receive an adequate response from CSC and as a result the midwifery service at that point were unaware of the CAF and previous involvement with the family regarding mother's parenting and her relationship with Child V.
- 6.8 The midwife reported that she did not ask mother the required question about domestic violence as her partner was present at the appointment. She said she knew there were plenty of other opportunities to do so in subsequent antenatal appointments. However she did ask appropriate questions of J and whether he had any children. He replied that he had a ten year old daughter but would not give her name or that of his former partner. J was described as 'attentive' during the appointment but the midwife was rightly concerned about his reluctance to disclose information about his daughter. Appropriately, she passed this information on to the midwife who would be supporting mother during her antenatal care.
- 6.9 There is no evidence on record that mother disclosed domestic abuse at any stage of her pregnancy, nor is there any suggestion that domestic abuse was a feature of this case. However, it is not clear from the review of records undertaken for this review whether or not mother was specifically asked about domestic abuse, as required.
- 6.10 As a result of this booking appointment, the midwife referred mother for consultant care because of her overall poor health.
- 6.11 Following a subsequent antenatal appointment in late February 2015, the attending midwife referred details of J (Baby F's father) to RAS. However, since the case was deemed closed, the midwife was not able to speak with the social worker who previously worked with the family. The midwife gave the father's name and date of birth and this information was entered onto system. The midwife also provided her contact details in case there were any questions about the family.
- 6.12 At the health visiting antenatal contact when Baby F was 7 months' gestation, it was documented in the health visiting antenatal records that mother told the HV she was not living with her baby's father (J) but they had planned for him to move in following the birth of the baby. No further information is documented in CWPT records regarding J or his role within the family. The HV antenatal records make no reference to Child V's ASD diagnosis or its possible challenges for the family. This may have been because the mother did not disclose this information.

### **Postnatal period**

- 6.13 Following the birth of Baby F, mother and baby were discharged home two days' later. In the postnatal period, mother and baby were seen for the primary postnatal visit by a midwife and both were reported to be well. Mother was reported to be well supported by her partner. Sleep safe advice was discussed with the parents and the sleeping environment checked. This indicates that recommendations from a previous SCR to check sleeping arrangements in addition to giving verbal and written advice have been embedded and followed by midwives. Further postnatal visits were undertaken including a home visit in response to a failure to attend the postnatal clinic. Baby F was gaining weight well and mother was reported to have 'excellent'

family support. It is not clear from records what this support involved nor whether the baby's father (J) was living at the family home. Postnatal checks were completed.

6.14 On day 5 after birth, the health visiting service received notification of the birth. The HV admin team organises the allocation of the primary visit which should take place within 10-14 days (a national requirement). The allocated HV rang to arrange this home visit.

6.15 Mother agreed the home visit for seven days later. The HV went as planned but no one was at home. HVs usually give a narrow timescale for a visit e.g. between 10.00-11.00am. The HV was going on annual leave so the next visit was re-allocated to another HV. She called the mother and left a voicemail to visit at 10.00am on 8 September. This was already in breach of the national timeframe for the primary visit as Baby F would be 25 days old by that date. Once again, no one was at home and the HV left a calling card. It should be noted that the majority of primary HV visits in Coventry are all within the national timescale of 10-14 days. There is no alert if this timescale is breached.

6.16 The HV wrote that she planned to discuss this second missed appointment with a HV colleague but there is no documentation to confirm this discussion took place. The CWPT has a 'Did not attend policy' (DNA) to support and guide staff when access is an issue. A minimal requirement is to inform the GP and the referrer, in this case, the midwife. The records do not evidence that this occurred.

6.17 Twelve days later and well outside the required time period, the HV attempted to visit the family at home but was met by a police officer and informed of the incident and that Baby F was in hospital. Baby F was not seen by anyone from the health visiting service prior to his injury.

6.18 It should be noted that after the birth, Baby F's mother visited the GP about her depression on 4 September 2015. Baby F was not assessed during this GP consultation.

### **Analysis**

6.19 CSC's response to the midwife's request for information was limited and inaccurate since the case was not closed in 2013. This has been acknowledged by CSC. One reason for this could be that only the initial assessment form on Child V's case file was looked at by the social worker. This form had concluded that no marks were seen on Child V, the relationship between the mother and child had improved and that Child V had been referred to CAMHS for her challenging behaviour. 'No Further Action' was noted but as indicated above, the file remained open to the referral and assessment service.

6.20 However, if the case notes had also been looked at, the social worker would have seen CSC involvement regarding further injuries. Furthermore, if there had been a full chronology on record, it would have been possible to see whether there was a pattern to the reported incidents and whether that had any implications for a new baby.



- 6.21 Health and educational professionals interviewed for this review have expressed their frustration at the lack of access to the case social worker if a case has been closed and therefore feel that they are not able to get sufficient relevant information on their clients; for example, when children/families are going on or coming off a CAF.
- 6.22 At the time of this incident, all contacts and referrals to CSC would be treated the same. Now the multi-agency safeguarding hub (MASH) has introduced a differentiated system to enable a more effective and efficient response.
- 6.23 Over the past year, the Acting Early model has been rolled out across the city and enables professionals/agencies working with 0-5 year olds to learn about the work of other colleagues/teams and to share information and concerns. If this model had been in place at that time, the midwife would have been able to use it to find out more about previous family history where a social care case is deemed closed, as in this instance.
- 6.24 During the antenatal health visitor contact, there was a lack of professional curiosity regarding the new father J and his role within the family. It is recognised that more information should have been sought during the antenatal contact about the potential impact on the siblings of a new baby and a new male moving into the family home at the same time, particularly in relation to Child V.
- 6.25 It is evident from records that mother gave conflicting information to different health professionals regarding the living arrangements for the new father, J and also regarding the state of her mental health during the pregnancy i.e in some cases reporting that she was in good health with no issues of depression while being prescribed anti-depressants by her GP. There is no evidence that communications took place between the GP, midwifery services or mental health services with the health visiting service and so these issues were not explored any further with the mother.
- 6.26 The primary antenatal health visit did not take place within the required national timescale of 10-14 days but there is no recorded evidence that the health visiting service made contact with the mother's GP practice to inform them about this lack of access to the mother and baby.

#### **Key Episode 4: Baby F's admission to hospital**

- 6.27 On 10 September 2015, Baby F was admitted as an emergency to UHCW with a serious and life threatening intracranial bleed. His father (J) attended with him; his mother was not present. He was resuscitated by senior medical and nursing staff and a detailed history of events leading up to his collapse was taken.
- 6.28 Following a head scan, the consultant leading his care discussed the findings with the father, his concerns about non-accidental injury and the need therefore to involve the police and social care. Details of this discussion and the father's response have been documented in the medical records.

6.29 Baby F needed intensive care provided in a tertiary paediatric centre. For this reason, he was transferred to Birmingham's Children's Hospital. UHCW provided a detailed verbal and written handover to the hospital's clinical team including a 'clear and unambiguous referral letter' from the on-call Paediatric specialist trainee who recorded that Baby F was felt to be the victim of non-accidental injury and as such would require further investigations including an ophthalmology examination and skeletal survey. In addition, the doctors at UHCW made immediate referrals to social care recognising the importance of safeguarding the welfare of other children in the family.

6.30 The management of this episode fully met the expected standards and rightly has been described as exemplary.

#### **Children's social care involvement since Baby F's admission to hospital**

6.31 A social worker was attached to this case from Baby F's admission to hospital and up to the first court date, a period of approximately four weeks.

6.32 Following a strategy meeting, it was decided that CSC undertake the supervision of the children and that Baby F's two half siblings would remain in the care of the maternal grandparents. A police officer and social worker visited the two children and Child V was described as a 'lovely child' who talked and did not appear to have any communication difficulties. The social worker supervised contact meetings between the mother and her two children. She also reported that J, the father of Baby F, seemed to be well known to the two half siblings who appeared comfortable with him.

6.33 There was a clear procedural response from CSC during this period with the allocated social worker working closely with police and medical staff. The social worker's involvement ended at court with the granting of the Interim Care Order; the two half siblings remain with their maternal grandparents and Baby F remains in foster care.

### **7. Findings and recommendations**

7.1 There is little information in this report about Baby F. In the few weeks prior to his non-accidental injury, there was limited contact with agencies other than midwifery and his subsequent emergency admission to hospital. There were missed opportunities for health visitor contact as a result of mother's failure to make herself and Baby F available for arranged HV calls and a failure to undertake the primary visit in his home. However, early midwifery visits report that both mother and baby were well. Baby F was gaining weight well and mother was reported to have 'excellent family support'.

7.2 It is not yet clear who was responsible for the serious non-accidental injury of Child F or how it occurred. There is no evidence from this review to indicate that this injury could have been predicted or prevented by agencies working with the family.



7.3 It is clear though from the review that this family met the threshold for a CAF and effective information sharing across the agencies, as happens now with the Acting Early model, would have identified this need prior to the birth of Baby F.

7.4 However, the three year scope of this serious case review has focused also on the older siblings, in particular on Child V, and on the way in which services worked with the family to support them. Reviewing the care of Child V was important for assessing the risks for Baby F. This review has identified similar concerns from recent SCRs examining practice over a similar timeframe.

7.5 Most notably, those include:

- poor quality and inconsistent record keeping within children's social care;
- the lack of an appropriate chronology for families involved with children's social care which identifies accurate information, professional concerns and a clear analysis of action to be taken or outcomes;
- an absence of the 'voice of the child', either in practice or in record keeping;
- a tendency for 'professional preciousness' which sometimes results in the non-statutory sector being excluded or marginalised from ongoing practice with a client/family;
- a lack of professional curiosity about new male partners, their past history as a father and the potential impact this may have on an existing family unit; and
- timely and accurate information sharing by children's social care with other agencies.

7.6 The Coventry LSCB should:

- seek assurance that the recommendation for each GP practice to hold multi-agency safeguarding meetings involving midwifery and health visiting teams is implemented so that timely, accurate information regarding vulnerable families is appropriately shared. Where relevant, these meetings should also involve school nursing teams;
- request that children's social care refresh its guidance on record keeping to ensure the accuracy and quality of chronologies maintained in case notes;
- reaffirm the importance of the voice of the child in the work of all services, and in particular, within social care practice;
- ensure that agencies requesting information from children's social care are clear about why the information is sought, and for what purpose; and
- seek assurance that there is a robust operational system in place to ensure that primary visits not performed in the 14 day timescale (where defined exceptions do not apply) are appropriately reviewed, responded to by the health visitor and appropriate actions taken.