Baby F Serious Case Review

Findings and Recommendations Report

Introduction

1. The overview report was commissioned by the Safeguarding Children Board as a Serious Case Review (SCR) following the serious harm to baby F in 2015. Baby F was a four week old baby boy who was admitted as an emergency to University Hospital Coventry and Warwickshire (UHCW) NHS trust with a serious and life threatening intracranial bleed. He was resuscitated by senior medical staff. Following a head scan, the consultant leading his care reported this serious and non- accidental head injury to the Police and Children's Social Care.

2. Baby F requires continuous care and is being looked after by Specialist Foster Parents.

3. Criminal proceeds were initiated where father was sentenced to 18 years for grievous bodily harm with intent. Baby F's mother was convicted of cruelty by neglecting him in a manner likely to cause unnecessary suffering by failing to get prompt treatment for him.

4. The family of Baby F were known to children's social care. The mother had been in contact with services sporadically since 2008.

5. The safeguarding children board serious case review committee met in October 2015 to consider the circumstances of Baby F's injuries. It was recommended that the case met 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.

6. 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 the context of how those agencies may have affected the work of their practitioners.

7. 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 serious case review process.

8. Daryl Agnew was commissioned as the Independent author to complete the SCR overview report and is independent of any of the services involved in this case.

9. At the initial scoping meeting, a three year timeframe was agreed for the review. The SCR committee also identified a number of issues for consideration by all agencies involved. They included:

- How well 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.

10. A panel of Senior Managers from each of the agencies involved was appointed to support the review process.

Summary and Conclusions

1. There is little information about Baby F in the report. In the few weeks prior to his non-accidental injury, there was limited contact with agencies other than midwifery and his subsequent admission to hospital. There were missed opportunities for health visitor contact as a result of mother's 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'.

2. There is no evidence from the review to indicate that this injury could have been predicted or prevented by agencies working with the family.

3. It is clear 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.

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 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 SCR's examining practice over a similar timeframe. Most notably these include:

- poor quality and inconsistent record keeping within children's social care;
- the lack of 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 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 accurate information sharing by children's social care with other agencies.

Recommendations

Recommendation 1- The 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;

Recommendation 2- The LSCB should request that children's social care refresh it's guidance on record keeping to ensure the accuracy and quality of chronologies maintained in case notes.

Recommendation 3- The LSCB should reaffirm the importance of the voice of the child in the work of all services, and in particular, within social care practice.

Recommendation 4- The LSCB should ensure that agencies requesting information from children's social care are clear about why the information is sought, and for what purpose.

Recommendation 5- The LSCB should 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 action taken.