Coventry Safeguarding Children Partnership

Serious Case Review Baby X

Date of serious incident: 29 June 2018

Date of report: October 2020

Agreed by Coventry Safeguarding Children Partnership: 4.11.20

Independent author: Daryl Agnew

Chair of Coventry Safeguarding Children Partnership: Derek Benson

1. Summary of the case

1.1 The subject of this serious case review (SCR) is Baby X. The baby was born at 33 weeks gestation. He was intubated and ventilated shortly after birth and was initially very unstable. He was treated for suspected sepsis. A cranial ultrasound scan prior to discharge revealed in retrospect a stroke. However, subsequent health checks at 11 weeks old indicated he was well, gaining weight and meeting his development milestones. The health visitor and GP had no concerns about him or his care.

1.2 Baby X was 4 months old when in late June 2018 he was left at home in the care of a family relative while his mother took his siblings to school. He was reported to be well when his mother left him. On her return he was acutely unwell, and an ambulance was called.

1.3 The ambulance crew found him in cardiac arrest and resuscitation attempts were prolonged. He was admitted as an emergency to University Hospitals Coventry & Warwickshire (UHCW) NHS Trust and later transferred to the paediatric intensive care unit at Birmingham Children's Hospital. His CT scan showed significant brain damage and chronic subdural haemorrhage. He remained unstable and further tests revealed brain stem death and bilateral retinal haemorrhages. After discussions with his parents, his care was withdrawn, and he died in early July 2018.

1.4 A forensic post-mortem attributed the injuries to non-accidental shaking as the primary cause of death. A criminal investigation was conducted and the sole member of the family present at the time was charged with the murder of Baby X. Subsequent criminal proceedings were concluded at Warwick Crown Court in December 2021 whereby the family member was found guilty of man slaughter and sentenced to 9 years

2. Terms of Reference

2.1 The following detailed terms of reference for the serious case review were agreed by the SCR Panel Meeting on 30 April 2019.

2.2 For individual agencies to review any statutory assessment carried out by their agencies, attendances at A&E and medical contacts specifically to consider:-

- the quality and appropriateness of any assessments undertaken, whether there were any indicators of neglect, significant harm, or other concerns that should have been actioned;
- whether there were any missed opportunities to intervene in the family, either with a view to providing support to the parents and / or children, or due to a need to escalate any concerns held about the family; and

- the extent to which professionals challenged or simply accepted the medical diagnoses reported by the parents in respect of the children.

2.3 The original focus of this review is Baby X and the non-accidental injuries sustained by him. However, it was agreed that the scope of the review would be a period of nine years beginning with the birth of Baby X's older siblings and the family's involvement with a range of agencies during that time, in particular health.

3. The Process

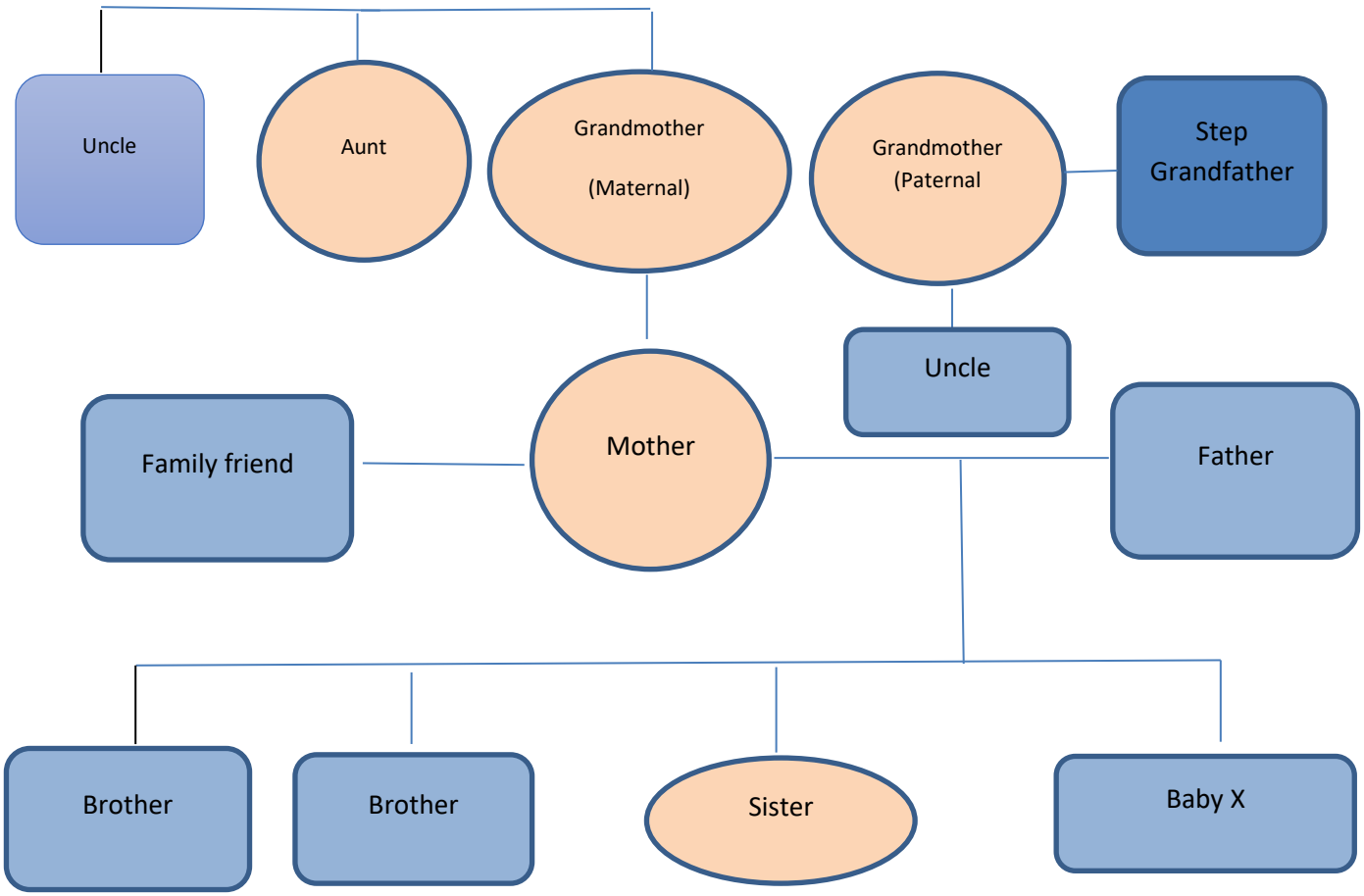
3.1 The Coventry Safeguarding Children Board (CSCB) Serious Case Review sub group undertook a rapid case review in August 2018 and a decision was made in September 2018 to undertake a serious case review as outlined in Chapter 4 of Working Together to Safeguard Children (2015).

3.2 Individual agency reports (IARs) and chronologies were sought from the agencies for this case.

3.3 This overview report is a brief summary and analysis of the evidence considered by the review panel.

4. Involvement with other agencies

Genogram



Health agencies

4.1 From the time of the birth of Baby X's siblings who were twins born in 2009, the family had considerable involvement with various health agencies. During 2009 and 2010 there were numerous attendances at A&E and at the Children's Emergency Department (CED). During this period the family were accessing health services via emergency care rather than through the more appropriate route of a family GP.

4.2 The reasons for these hospital visits were various ranging from gastro-enteritis, respiratory infections, attendances for 'funny turns', a possible epileptic seizure, an accidental injury sustained when one of the twins fell from a sofa on to a carpeted floor and a reported concern that one of the twins had spina bifida. A picture emerges of anxious parents who were struggling to cope and did not know how to access the most appropriate health services.

4.3 Throughout 2010, the children were brought to hospital increasingly by the parents with reported illnesses and problems, few of which were directly observed by health professionals. There is some evidence of the parents being signposted to other agencies and of information regarding the family being shared across the different health agencies.

4.4 However, a referral in 2010 to attend Consultant Paediatric sessions following the earlier hospital admission of one twin for a possible epileptic seizure indicated that the child was not brought to the appointment. Results of brain wave tests showing no abnormality had been sent to the parents and GP beforehand, so this may have been the reason for their failure to attend. Two days later, the twin was again presented at the Children's Emergency Department as mother reported the child to be lethargic. However, following further examination and parental reassurance, the child was discharged home.

4.5 During 2011, there were numerous hospital attendances and involvement with health visiting services. Both twins were seen by the speech and language therapy service (SALT). Mother reported sleep and behaviour management difficulties for the twins and requested support which was provided.

4.6 A third sibling was born in the summer of that year and in the autumn, following a bump to the head, was brought promptly by his parents to the CED. It was reported that the baby had been sleeping on the sofa when an older sibling picked him up and dropped him onto a wooden floor. A head scan revealed a hairline fracture of the skull. Following overnight observation, the baby was discharged home the next day.

4.7 In summer 2013, the second twin was brought to CED after a reported fall the previous day from a chair on to wooden decking in the garden. At the time, the child continued playing so medical advice was not sought. The next day the child woke with a headache and was brought to CED. On examination the child was

documented as being alert and routine observations were normal. The child was discharged with head injury advice.

4.8 A diagnosis of Autistic Spectrum Disorder (ASD) was confirmed for one of the twins in November 2011. Health records at that time indicate that the parents were expressing their 'lived experience' to practitioners. It was recognised that the family needed support as they found the behaviour of their twin children increasingly challenging. In 2013, their third child was referred to the Community Paediatric team by his GP for a possible diagnosis of ASD and subsequently the diagnosis was confirmed in late 2015. In 2014, a Consultant Neuro-disability Paediatrician confirmed a diagnosis of ASD for the second twin.

4.9 During the course of the next three years or so, all three siblings were supported with developmental, behavioural and sensory issues relating to their ASD diagnoses such as speech and language difficulties, aggressive behaviour and sleep problems. In some instances, services such as SALT and Child and Adolescent Mental Health (CAMHS) recorded examples of the 'voice of the child' being heard and how the children presented on occasion. A SALT therapist recorded her observation of one of the twins interacting with his mother, showing affection and interest in his mother and seeming 'at ease in his own home'. On another occasion, a health professional recorded using signs and expressions to communicate with the child.

4.10 The health visiting service[1] was involved with all four children in this family between 2009 and 2018. A review of health visiting records indicates that the service had good engagement from the family with both parents contacting the service at different times when additional support was required. The service conducted all health assessments in line with the service specification, with visits taking place both within the home and in clinic locations. The service was notified on the occasions when children were seen at the CED and appropriate follow-up took place. However, there is no evidence that staff considered any wider safeguarding issues within the family.

4.11 During 2011, the parents requested additional support from the service on three occasions regarding the behaviour of the twins and the impact on their mental wellbeing. Appropriate support was signposted (i.e. to the GP and a referral to the Children's Centre). It has been recognised however that there was a lack of professional curiosity at that time into any additional family stressors or a wider assessment of any impact on the children.

4.12 Following the birth of the third child, early identification of depressive symptoms in mother was made during the six week postnatal assessment. The health visitor put a plan in place and made four additional visits to support mother. However, there

[1] Since September 2018, health visiting and school nursing services for Coventry have been provided by South Warwickshire Foundation Trust (SWFT) and before that by the Coventry and Warwickshire Partnership Trust (CWPT).

is no evidence of any liaison between maternity and health visiting services during the pregnancy or during the immediate postnatal period.

4.13 The health visiting service was made aware of the children's numerous visits to CED during a four year period with differing symptoms (i.e. through the Paediatric Liaison notification process) and did contact the family to discuss the attendance and to offer additional support and advice. However, there is no documentation to suggest that these frequent attendances were explored further, or any patterns noted in the reasons for them. In isolation these attendances could have been dismissed as minor childhood illnesses nature of the attendances and their frequency seem to indicate a family struggling to cope.

General Practice

4.14 Baby X and his family were registered at a health centre in the city. A key 'procedural' incident was identified as part of this review process. The incident occurred in January 2018 during mother's pregnancy with Baby X when a social worker contacted a midwife at the health centre. The social worker had recently undertaken a Child and Family Assessment in response to concerns that the parents had allowed a 'risky adult' (known to social services) to live with them. An earlier request for information as part of the C&F assessment had been faxed to the practice. The midwife was informed that the assessment would soon be closed, and no further action required. A request was made that if any home visits were undertaken and there was a male adult and a twelve year old boy in the house, children's social care should be informed. This information was shared subsequently at a Multi-Disciplinary Team meeting in the practice.

4.15 The SCR review process revealed that there were no entries in the medical records about the original fax from children's social care or any request for information. However, there had been 'four attempts' recorded by children's social care to gain information through a fax to the GP practice. After a telephone request, the information was eventually transferred back.

4.16 It is important to note here that practice in gathering information between social care and GP practices has since changed. Historically, social workers would fax a non- specific request for information to GPs. Early in 2019, communications improved with the development of a new pro-forma ('V5') which was agreed (via the Safeguarding Children Board) between Primary Care and Children's Social Care. The new V5 pro-forma clarifies the purpose and context of the request, actions currently planned and the specific information that is being requested for any safeguarding matter. It has been reported to the review panel that the efficiency and quality of information sharing between social care and GPs have improved as a result of these changes.

4.17 A second 'procedural' incident was identified by the GP practice regarding 6-8 week baby checks. When questioned about this check by the practice nurse, mother reported three failed attempts to book this check for Baby X at the health

centre. A new procedure has been introduced when registering a new-born child whereby a recall is added to the computer system that triggers at 8 weeks of life. This recall prompts the surgery to audit whether the check has been completed or booked for completion. Failure to do so is proactively followed up by the surgery until the check has been completed.

Children's services

4.18 Coventry Children's Services had limited involvement with the family prior to the death of Baby X. In early 2017, a referral was made by the older siblings' primary school reporting that all three children were currently staying with the maternal grandmother due to concerns about a risky adult who was believed to be part of a gang 'scamming' people and who was staying in the family home. In order to protect her children, mother had sent them to stay with their grandmother to ensure they were safeguarded. Children's services were satisfied that the mother had put enough measures in place to safeguard her children. A Multi-Agency Support Hub (MASH) assessment was completed and a referral made for the primary school to offer a level 2 CAF. The mother however declined the offer of CAF support from the school.

4.19 A second referral made by a social worker took place in late 2017 during the mother's third pregnancy. The social worker was involved in the case of a father and son who were known to children's social care. It was alleged that they were staying with the family and potentially presented a risk to the children in terms of alcohol misuse and inappropriate language in the family home. A Child and Family Assessment was completed in January 2018 with an outcome of no further action. It concluded that while Baby X's parents were defensive about the allegation and/or potential risk, they denied having the two males living with them. The parents were assessed as being able to ensure their children were safeguarded. There were no concerns noted at that time with regards to the parents' direct care of the three children or of the unborn child.

4.20 A written agreement was put in place in respect of mother ensuring that no unsupervised contact would take place between her children and this man and his son. The case was subsequently closed in early 2018. It is no longer the practice within children's services to use 'written agreements' of this nature. Current practice would involve a safety plan for the children with clear expectations for the family.

4.21 As part of the serious case review, children's services acknowledged that the CFA in January 2018 could have been more detailed and should have also referenced the referral of the family to the MASH in early 2017. The CFA could have also considered a more in-depth assessment of the historical non-attendance at autism awareness sessions by the parents. Children's services reported that this would not have had any impact on the decision to close the case at that time.

4.22 Children's services have identified that on both occasions when the case was closed either directly at the referral stage by the MASH or by the area team

following completion of the child and family assessment, there is no record of closure letters being sent to the family or other professionals working with them detailing the decisions. This was a weakness in information sharing.

4.23 A referral was made by paramedics to the MASH following Baby X's admission to hospital in June 2018. It was appropriately identified as a priority safeguarding concern and the potential for non-accidental injury was clearly recorded. Given the older siblings in the family, it would have been appropriate to have held that same day a strategy discussion, an S47 investigation initiated and a home visit undertaken to ensure timely safety arrangements were in place, pending further assessment. This would have enabled an important multi-agency discussion from the outset. In practice, the strategy discussion took place four days later; the home visit two days later. This delay has been acknowledged and the local authority has issued new guidance and provided training on strategy discussions to address these weaknesses.

4.24 The family relative who was caring for Baby X at the time of the non-accidental injuries was not known to children's social care or to the police.

Education

4.25 All three siblings have diagnoses of Autistic Spectrum Disorder and their needs are managed within their primary school through a range of in-school strategies. None of the children have individualised education plans or Education Health Care (EHC) plans. At the outset of this review, it was reported that no external agencies were involved with the children as their primary school can access support from the Coventry Autism Support service if required. During their time at primary school, the children's medical concerns have had an impact on their school attendance.

4.26 The review process by the school revealed one incident with implications for future practice. In late 2017, the school was contacted by children's services as they were undertaking a Child and Family Assessment on the family (see paragraph 4.16 above). Following this initial contact by children's services, there was no further contact. The school made enquiries but received no further information regarding this CFA assessment or the outcomes. The school reported that it was only after the death of Baby X that the concerns of health agencies about missed health appointments by the children became known to school staff.

Police

4.27 West Midlands Police (WMP) had no involvement with the family until 2017 when there were two referrals through the MASH (see above paragraphs 4.18 and 4.19). Both events relate to MASH processes and the sharing of information between agencies.

4.28 The first incident in early February 2017 was reported by the children's school after they were informed that the three children were staying with grandmother due to

concerns about a risky adult staying in the family home. The matter was appropriately recorded on a Child Abuse Non-Crime report and evaluated as an Amber MASH referral. During strategy discussions at the MASH, information was shared, and the poor school attendance of the children was noted. There was no information shared to suggest the children were at risk of serious significant harm, and in light of this, it was recommended that the school offer a CAF to the family to explore and improve the attendance. As noted above (see paragraph 4.18), this offer was subsequently declined by the mother.

4.29 In late 2017, a second Child Abuse Non-Crime report was generated following a further Amber MASH referral made by a social worker regarding a child not related to the family who was residing within the family home along with his father. The father and son considered themselves to be homeless and were housed on an informal basis by the family (see paragraph 4.19). Following the strategy discussion within the MASH, a Child and Family Assessment was recommended with a specific focus on the parents' understanding and management of risk for their family.

5. Analysis of professional involvement with the family

5.1 It is clear that all three children had complex health needs and mother expressed her 'struggles' during home visits by health visitors. Professionals liaised with parents to encourage attendance at appointments and numerous telephone calls were made to remind parents of planned home visits and appointments. However, there is no evidence of any conversations with the parents about the impact of caring for three children with complex health needs on their own health and mental wellbeing, nor of the practical difficulties faced by them in taking the children to numerous different appointments.

5.2 Records indicate that there were occasions during 2011-2012 when children were not brought to health appointments. Records also indicate that mother rang to cancel some appointments for reasons such as child unwell, childcare issues or other medical appointments. There was no pattern identified of individual children not being brought for appointments and no indicators of neglect identified. The Trust's 'Did Not Attend' (DNA) policy was followed appropriately with phone calls and letters to parents but opportunities for further discussion between the services about the meaning behind the non-attendance or the impact on the children of frequent non-attendance do not appear to have been taken.

5.3 The escalating needs of the family between 2009 and 2013 were recognised by the health visiting service and additional support put in place. However, despite the involvement of numerous agencies there appears to have been little consideration at the time of how best to coordinate this involvement in the form of an Early Help or a Common Assessment Framework (CAF) plan.

5.4 Records of follow-up visits by health visitors following the falls of the twin in 2010 (see paragraph 4.2) and the third sibling in 2011 (see paragraph 4.6) do not include

any further discussion with parents regarding the falls or consideration of any wider safeguarding issues. In retrospect it is not clear why this discussion did not take place. It may have been due to professional over optimism given that the parents engaged well with the service or an assumption at that time that hospital staff would have considered the wider safeguarding issues.

5.5 During the period of time the health visiting service was involved with the family, the children attended the CED on numerous occasions with differing symptoms. The service was informed of these visits through the official notification process however not all of these attendances were recorded in the main health visiting record. This inconsistency could have resulted in attendances being seen in isolation rather than in the wider family context. At the time of the third sibling sustaining a hairline fracture (see paragraph 4.6) the family context included a mother being treated for depressive illness caring for three children under the age of 3, two of whom had challenging behaviour that was being investigated further.

5.6 As part of this review process, health professionals recognised that a Common Assessment Framework (CAF) could have been undertaken to provide an opportunity for different agencies to consider the risks and vulnerabilities for the family and to identify their support needs. There were numerous contacts with the family, but it appears that practitioners were reactive, and incident led, responding to each health need and missing the opportunity to consider the needs of the family as a whole, to 'Think Family', as would be the practice today. There was a lack of professional curiosity into any additional family stressors. Use of an early help model would have offered a co-ordinated approach and a means of assessing how well the parents were coping with the differing demands of their three children.

5.7 The voice of the children and their lived experience are not evident in the children's health visiting records considered for this review. There is little description given as to how the children presented when seen. Parental issues have been identified and managed but there is no indication of how these issues impacted on the children or information of the home conditions. In addition, the CFA assessment undertaken by children's services in late 2017 did not include any recorded evidence of the 'voice of the children' despite concerns about risky adults in the family home.

6. **Findings and recommendations**

6.1 The judge for the Findings of Fact hearing at the Family Division of the High Court of Justice in spring 2020 found that 'neither the mother nor the father caused any harm to or inflicted any injuries' upon their baby. He also found that 'there was no question of them failing to protect their baby' from the family relative involved in this case or any other person.

6.2 There is no evidence from this review to indicate that the injuries sustained by Baby X could have been predicted or prevented by agencies working with the family.

6.3 It is clear however from the review that this family met the threshold on two occasions for a CAF and effective information sharing across the agencies, as happens now with the 'Acting Early' model, would have identified the needs of the family prior to the birth of Baby X. However, early help is a voluntary process and at the time the mother declined these offers.

6.4 Coventry Safeguarding Children's Partnership policy and guidance 'Right Help, Right Time' (2018) is comprehensive and clearly sets out the shared responsibilities professionals from all agencies have to ensure that children receive help early and at a level according to their needs. Through ongoing training and supervision, staff from across the multi-agency partnership are encouraged to adopt a 'Think Family' model to assess the needs of all the children in a family and to access appropriate help.

6.5 The nine year scope of this serious case review focused mainly on the older siblings and the way in which different agencies worked with the family. This review has identified shortcomings in the practice of some services at that time and action has been taken within the past two years to address these issues.

6.6 The findings of this review show the changes in processes introduced in recent years include the following improvements:

a. Information gathering between social care and GP practices has been improved by the introduction of a new pro-forma ('V5') which clarifies the purpose and context of a social care information request, the actions currently planned and the specific information that is required for any safeguarding matter. Historically, social workers would fax a non- specific request for information to GPs which sometimes resulted in delayed and/or inadequate responses.

b. A new procedure has been introduced in GP practices when registering a new-born child whereby a recall is added to the computer system that triggers at 8 weeks of life. This recall prompts the GP surgery to audit whether the baby's check has been completed or booked for completion. Failure to do so is proactively followed up by the surgery until the check has been completed.

c. Children's social care no longer use written agreements with parents as identified in paragraph 4.20. Current practice now would involve the development of a robust safety plan for the children with clear expectations for the family.

d. The delay in holding a strategy discussion following Baby X's admission to hospital (see paragraph 4.23) has been acknowledged and the local authority has issued new guidance and provided training on strategy discussions to address these weaknesses.