CONFIDENTIAL

SERIOUS CASE REVIEW

Baby K

Overview Report

October 2018

ViSOR Safeguarding Limited

1. INTRODUCTION

1.1. On 7th March 2017 Newcastle Safeguarding Children Board (NSCB) Case Review Committee considered details of the unexpected death of Baby K, aged 13 weeks old, who died from a non-accidental traumatic head injury.

1.2. Regulation 5(1)(e) of the Local Safeguarding Children Board (LSCB) Regulations 2006 requires the Board to undertake reviews of serious cases (SCRs) and 5(2) defines a serious case to include one where 'abuse or neglect of a child is known or suspected, and the child has died.'

1.3. In 2015 Chapter 4 of the guidance within "Working Together to Safeguard Children" emphasised the importance of a Learning and Improvement Framework which includes Serious Case Reviews and stipulates that such reviews should be completed in a way which: -

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

1.4. The guidance further states that LSCBs may use any learning model which is consistent with its principles, including the systems methodology recommended by Professor Munro.

1.5. It is an unusual aspect of this case that Baby K and his siblings were previously known only to universal services, there were no apparent indicators of any failings in the work undertaken by agencies to protect children nor were there any indicators of concern about abuse and neglect. However, a CT scan gave evidence of a bilateral acute subdural haematoma, brain oedema and massively raised intracranial pressure. Medical opinion stated that Baby K had died of an inflicted and traumatic non-accidental injury and this became the subject of a criminal investigation by the Police. The Independent Chair found that in these circumstances the criteria for a Serious Case Review were met.

1.6. Baby K's mother and father were made aware that a Serious Case Review had been commissioned in March 2017 and subsequently invited to contribute when the criminal proceedings concluded in August 2018. Neither parent responded to the invitation.

2. SCOPE OF THE REVIEW

2.1. In view of the short life of Baby K and the limited contact with services, this is an unusual case for review and therefore it is appropriate to consider the entire life of

Baby K and indeed where relevant take reference from similar contact his siblings had with services.

2.2. Simple questions in this case remains the same, were there any missed opportunities for

- Effective information sharing?
- Robust single and multi-agency assessments?
- Identification of any risk factors?
- Provision of support services to the family?

2.3. However, and again reflecting on the unusual circumstances, it must be stated at the outset that there was no evidence of any concern for Baby K and thereby no incidents that could have benefitted from information sharing between agencies to protect him from abuse or neglect. This review has therefore stretched the normal scope in the search for any potential learning from this case.

3. METHOD OF THE REVIEW

3.1. All the agencies known to have been involved with the child were asked to review their records, prepare a chronology and identify any records relevant to the SCR.

3.2. Three agencies were asked to submit individual Serious Case Review Reports, these were:

- North East Ambulance Service (NEAS)
- Newcastle Gateshead Clinical Commissioning Group
- The Newcastle upon Tyne Hospitals NHS Foundation Trust (NuTH)

3.3. It is relevant that, other than the investigation after the discovery of Baby K's death, no other agencies were involved in the child's life.

3.4. The SCR has been carried out in accordance with the statutory guidance and principles set out in Chapter 4, Working Together to Safeguard Children 2015.

3.5 During the preparation of the chronology the authors identified and spoke to key members of staff. One further interview with a key practitioner was undertaken during the preparation of the single agency reports.

4. PARALLEL PROCEEDINGS

4.1. Northumbria Police conducted the criminal investigation following the death of Baby K and father was charged with manslaughter. He was subsequently acquitted by the Court of the charge. The Senior Investigating Officer has offered full support to the review process.

5. TIMESCALE FOR COMPLETION OF THE SERIOUS CASE REVIEW

5.1. The anticipated timescale for completion of a Serious Case Review set out in statutory guidance is six months. The review commenced on 7th March 2017 and has been delayed due to the parallel criminal investigation.

5.2. Progress of the review was in partnership with the NSCB and it was the responsibility of the relevant partners to respond to all issues as they emerged.

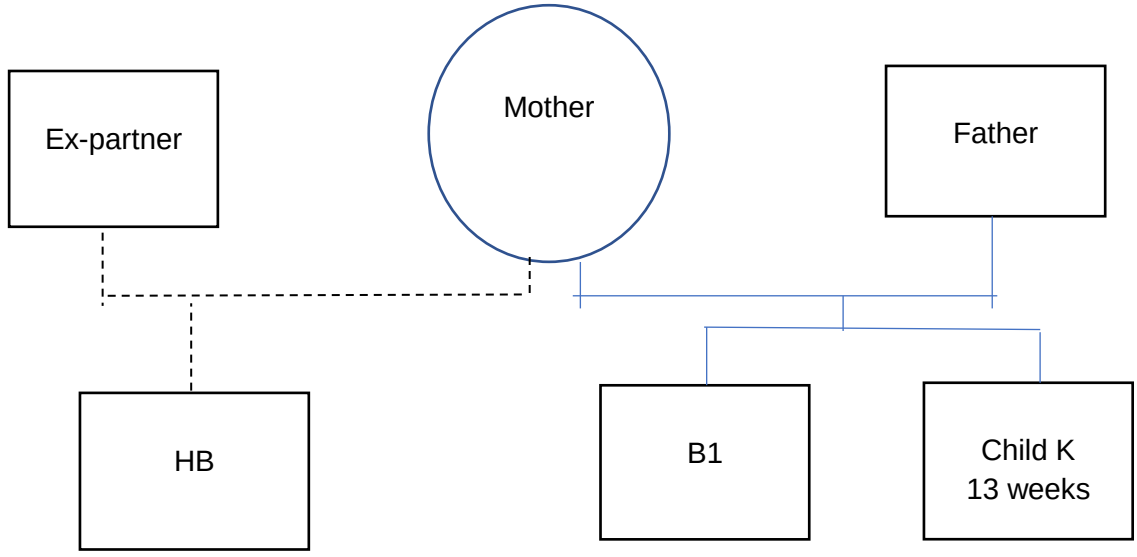
6. A REVIEW THAT IS FAIR AND THOROUGH

6.1. As well as the scrutiny and evaluation of the events in the short and tragic life of this baby the SCR has sought to consider all potential areas of learning. The absence of any cause for concern prior to death has led to the consideration of scenarios founded on limited evidence but nevertheless parallel to relevant learning from research, legal precedent and a previous SCR in Newcastle.

6.2. Like many SCRs there has been an advantage to not only be able to review the composite history of professional involvement with the child but also to do so with the corresponding resource and time to forensically examine those events.

6.3. It has been considered that such scrutiny may indicate to frontline practice that signs and symptoms of abuse could have been recognised and acted upon. However, the search for learning and service improvement should not be construed as a gap in agency or partnership practice.

7. GENOGRAM



7.1. HB – Half-Brother, B1 - Brother

8. SUMMARY OF THE CASE

8.1. Baby K was born at 39 weeks pregnancy following a normal delivery from which no concerns were raised. Baby K and mother were discharged the following day.

8.2. Between April 2016 and July 2016 Baby K was seen by professionals on nine separate occasions.

8.3. The Community Midwife visited Baby K on 3 occasions in April 2016. During one of the visits it was noted by the Community Midwife that Baby K was gaining weight and was described as a normal and well baby. This was confirmed on a follow up contact whereupon Baby K was discharged by the Community Midwife and transferred to the Health Visiting Team.

8.4. Baby K was seen on 4 occasions by Health Visitor between April and July 2016 and was also seen at home by the health visitor and a student nurse for the Primary Visit. Routine topics that were discussed included shaken babies, coping strategies for an unsettled baby, prevention of Sudden Infant Death (SIDS), home safety, safe sleeping and the availability of local services. It is documented in the health visitor records that Baby K was continuing to gain weight and parents were observed to be handling Baby K confidently with warm and loving interactions. Mother informed the health visitor that Baby K had a repeat hearing test appointment in May 2016.

8.5. Again, in May 2016 Baby K was observed to be gaining weight, alert and responsive. The health visitor risk assessed Baby K as having no additional needs above universal provision of the healthy Child Programme and arranged a 6-week appointment. Mother reported that Baby K had passed the hearing test carried out the previous day.

8.6. Later in May 2016 the health visitor undertook the routine 6-week appointment. Mother stated Baby K was slow to smile. A routine domestic abuse enquiry was made with no disclosures, SIDS guidelines and safe handling were also discussed as were the signs and symptoms of low moods or anxiety, but mother stated she had recovered from the birth and denied any low mood. It was observed that home safety equipment was in place and that there was interaction and contact between mother and baby throughout the visit. There was also a note that the family were planning to move home.

8.7. In July the health visitor visited the family in their new home. Mother stated she was feeling well both physically and emotionally and happy to be living in a new home. A further routine enquiry was made about domestic abuse, but mother dismissed any such any abuse. Safe alcohol use, SIDS guidelines as well as strategies to cope with a crying baby were again routinely discussed. Baby K was observed to be vocalising and smiling with good head control. Mother stated she had no problem settling baby K; good routines were in place for bedtime and although he did not get upset often, when he did, he easily settled when held.

8.8. The other health related contacts were for a routine hearing test and a GP six-week check-up. No concerns were identified.

8.9. Interviews with the health visitor enabled further consideration of frontline practice and observations of Baby K.

8.10. Mother was undertaking a childminding course and had been subject to home safety checks by Ofsted. She was always polite and appeared prepared for visits but would openly say that she would '*do things her own way'*, she had high expectations of her older children and was vigilant of home safety. She had seemed offended at the question of domestic abuse and discussion was extended to cover wider aspects of abuse beyond physical. The health visitor felt that visits seemed "*superficial"* in nature on the part of mother, she retained a strong desire to design the care for her children and the practitioner considered the possibility that she may not disclose any issues if they had been present.

8.11. Father was seen only once at the primary visit at which time it was noted that he had a healthy interaction with one of the older children. The practitioner recalled there was no direct verbal interaction between mother and father as he was looking after the older sibling, but he did respond to the health visitor when she asked questions. The health visitor had no concerns with father's engagement during this visit and has since reflected and commented that the behaviour of the child father was looking after did not change after he left.

8.12. There were no signs of concern for any of the children, indeed many positive features were noted in their welfare and development.

9. OTHER RELEVANT HISTORY

9.1. B1 was born in 2014 and records show Health Visitor conversations regarding coping with crying baby and prevention of shaken baby and prevention of SIDs were discussed with mother on two separate occasions. This was associated with relevant observations of the interaction between mother and B1

9.2. In November 2016 during a routine 9-12-month development review with the Nursery Nurse, mother disclosed that she had suffered domestic abuse with her previous partner, and that she had left of her own accord. There is no record of any report to the Police or other agencies of this.

9.3. The Community Midwife discussed the issue of domestic abuse with mother while alone in September 2016.

9.4. In December 2016 HB was seen by a GP in response to suspected asthma, the records of the GP comments that the '*family appears complex*' but it has not been possible to clarify this any further.

9.5. Interviews with staff and records demonstrate regular communication between the Nursery Nurse and Health Visitor about the care and welfare of B1.

9.6. HB suffers from allergies (Atopy) and B1 has an intolerance to milk. Medical records demonstrate a commitment by M to respond positively to these demands and access medical care.

9.7. It is understood that father was in full-time employment.

10. RESEARCH CONSIDERED

10.1. In a triennial review of SCRs, evidence suggests that 41% related to babies under one year old, which reflects the intrinsic vulnerability of babies who depend on their parents for care and survival (Sidebotham et al 2016).

10.2. Newcastle Child J Serious Case Review was considered but in the absence of any issues of concern in this case the findings from Child J were broadly discounted.

11. APPRAISAL OF PRACTICE

11.1. The history of this case demonstrates regular interaction with mother and, in line with procedure, routine discussion of strategies to cope with a crying baby, prevention of a shaken baby and the prevention of SIDs. There are records of clear and relevant observations of the interactions between mother and baby including mother's own input into her successful techniques. Despite the confidence of mother, practitioners have reflected on the superficial interaction by her with professionals and her robust stance to design the care of her children '*her way'* as everything was always *'fine',* prompting practitioners to consider if mother would have disclosed issues if things were not *'fine'*.

11.2. There is evidence of limited interaction with father. In the context of the tragically short life of Baby K it is difficult to consider the impact of this on the assessment of risk. There is nothing to suggest that father was deliberately absenting himself from business and that such absence was only due to his employment which is not unusual with working parents. Indeed, practitioners demonstrated that they have taken the opportunity to observe the behaviour of B1 and note that behaviour was consistent whether father was present or not. This also presented an opportunity to speak to mother separately from father and there is a clear demonstration that this did not restrict the assessment of care provided by mother alone. Whilst the involvement of father over a longer period would have benefitted the ongoing assessment, the opportunities taken by practitioners is a further demonstration of professional sound practice.

11.3. The assessments of the care for Baby K appear well founded on the evidence at hand and the completion of risk assessments clearly demonstrate a structured decision making in considered judgements. These assessments are strengthened by the regular communication with the nursery nurse for B1. There is no evidence of formal supervisory oversight, but this does not detract from the assessments

within this review. This assessment and the interviews with practitioners demonstrate that the assessment does not discount areas of uncertainty or dismiss areas of risk, moreover there is a clear cognisance of these considerations as discussed within this section.

12. EMERGING THEMES AND LEARNING FROM THIS REVIEW

12.1. The intrinsic vulnerability of babies.

12.2. Areas of consistent established practice e.g. recognising and acknowledging that the absence of any indicators of abuse does not eliminate risk.

12.3. Agencies considering alternative contacts to accommodate working fathers to able to attend home visits or appointments.

12.4. Risk Assessments to have a reflective review by supervisors.

12.5. The benefits of having an open, non-incident based approach to all forms of abuse within the family, supported by structured enquiry, professional practice and awareness that a victim may not disclose or even identify the existence of abuse

13. CONCLUSION

13.1 There is no evidence to suggest that any agency had the opportunity to foresee or prevent the tragic death of Baby K.

14. RECOMMENDATIONS

14.1. There are no recommendations from either the Overview or the individual chronologies prepared as part of the review papers.

15. References

Cuthbert, C; Rayns, G; Stanley, K. (2011), *All Babies Count.* NSPCC

HM Government 2013: *Working Together to Safeguard Children.* DfE

HM Government 2015: *Working Together to Safeguard Children.* DfE

Newcastle Safeguarding Children Board (2016): *Serious Case Review Child J*

Sidebotham et al. (2016), *Triennial Analysis of Serious Case Review* 2011-2014. DfE