Serious Case Review

Child ‘T’

Barnsley Safeguarding Children Partnership

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1. Introduction

Child 'T' was born in Barnsley on the 27 September 2018.

On 30 November 2018 the Mother of Child T (MCT) called for an ambulance to attend the home address as Child T was 'Floppy'.

He was conveyed to Barnsley Hospital but was later transferred to the Sheffield Children's Hospital where he died on 3 December 2018.

He was nine weeks old.

Medical evidence shows that he died of non-accidental injuries which led to a homicide investigation being commenced by South Yorkshire Police. That investigation is ongoing at the time of writing this report. His injuries included a very serious injury to his brain and fractured bones.

A decision was taken by the Barnsley Safeguarding Children Board to commission a Serious Case Review to establish if there were any lessons to be learned that would help to safeguard other children in the future.

2. Why Commission a Serious Case Review (SCR)?

At the time of Child T's tragic death, the partnership arrangements for Safeguarding Children in Barnsley was the Barnsley Safeguarding Children Board which was operating under the Department for Education guidance document 'Working Together to Safeguard Children 2015'[1]. Included in that guidance document is the criteria of circumstances that should result in an SCR being commissioned:-

> *Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of LSCBs. This includes the requirement for LSCBs to undertake reviews of serious cases in specified circumstances. Regulation 5(1)(e) and (2) set out an LSCB's function in relation to serious case reviews, namely:*
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> > *5(1)(e) undertaking reviews of serious cases and advising the authority and their Board partners on lessons to be learned.*
> > *(2) For the purposes of paragraph (1) (e) a serious case is one where:*
> > *(a) abuse or neglect of a child is known or suspected; and*
> > *(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.*

It can be seen that Child T's death meets the circumstances described in Regulation 5 (2)(a&b), in that abuse or neglect of a child is known or suspected and the child has died.

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1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/592101/Working_Together_to_Safeguard_Children_20170213.pdf

Chapter four of Working Together to Safeguard Children 2015 sets out the principles of an SCR which includes:

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;

- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;

- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;

- Professionals must be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;

- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.

The aim of this SCR is to establish if there are any lessons to be learned that may help to safeguard other children in the future; it is not to apportion any blame.

This SCR does not enquire into who may be responsible for Child T's injuries that resulted in his death. That is the role of the Police investigation. Care has been taken to ensure that this SCR does not compromise or interfere with that homicide investigation.

In line with the principles shown above, it is a proportionate review.

3. Methodology

The author is independent of the agencies that engaged with Child T and his family.

The approach has been to-:

- Look at records kept by agencies and to see if they evidence compliance with policies and procedures
- Speak with members of staff who interacted with the family
- Liaise with the police investigators to ensure that this review did not compromise the police investigation.
- Liaise with a Doctor who has a role in Safeguarding within a Clinical Commissioning Group
- Identify any aspects of good practice.

Given that this review took place whilst the police homicide investigation was ongoing, it was agreed that it would be inappropriate for the author to meet with Child T's parents. However, it was considered that it was important that his parents were aware of the review and be given the

opportunity to make a written submission to the author, if they so wished, on the services that they, and their child, received. The author sent a letter to the parents but received no response.

4. Background Information

The parents of Child T were/are in a long term relationship and Child T was a planned first baby for the couple.

Prior to MCT (Mother of Child T) becoming pregnant, the parents were not known to any services connected to children. Neither parent had any previous involvement with Children's Social Care, nor were they known to the police for any incidents of Domestic Abuse or for any previous convictions or cautions for any offences that may give rise to concern about their ability to care for a child. They were not known to substance misuse services or Mental Health Services.

The risk factors of Domestic Abuse, Mental Health and Substance Misuse, often referred to as the Toxic Trio, which are a feature in many cases of child abuse and neglect, were not evident in this case.

From the point that MCT is confirmed pregnant by the General Practice Doctor, the access to universal services, that is those services which are available to all pregnant women, was as would be expected. There was one exception to that, which I detail below, but it has no bearing on the case.

The Midwifery Service is provided by Barnsley Hospital NHS Foundation Trust and the Health Visitor Service is provided by the Public Health element of Barnsley Metropolitan Borough Council.

The Midwifery Service informs the Health Visitor service of women who are pregnant and who have begun to be engaged by their service. In Child T's case this notification took place in July 2017.

The Health Visitor Service normally carry out a Home Assessment visit prior to the birth of the child in order to introduce themselves to the mother/family and to carry out an assessment of the home's readiness and suitability for the arrival of the baby. Before making contact with the mother to arrange the visit, the section of the Health Visitor Service that covers where the family lives, send an email to the Midwifery Services to get confirmation that the pregnancy is still viable. The reasoning for this confirmation email is to avoid a Heath Visitor making contact with a family where there has been a problem with the pregnancy and thereby causing unintended upset. The Health Visitor Service did not receive a response to their email and so did not carry out that initial visit. As stated above, this had no bearing on the case and did not put Child T at risk; all necessary checks and assessments were completed after the birth and did not raise any issues of concern. The Midwifery Service have checked for receiving the email but cannot trace it. They do have a pathway that informs Public Health in the event of a foetal death; that pathway did not apply in this case.

Managers within both Public Health and the Midwifery Service are aware of the communication issue that resulted in the missed home assessment visit by Health Visitors. They are taking action to resolve it. Whilst the missed appointment had no impact in this case, both services recognise that it could have an adverse impact in other circumstances.

Throughout her pregnancy the parents of Child T fully engaged with the ante natal system run by the Midwifery Services. MCT attended all expected appointments, in some instances she was

accompanied by her partner, on others she was unaccompanied. This mix of accompanied and unaccompanied visits is helpful to professionals; it allows them to get to know the father (FCT) of the child and to involve him in the conversations about risk factors whilst unaccompanied visits allow professionals to speak with mother about sensitive subjects such as whether or not they are a victim of Domestic Abuse. The records kept by the individual midwives display a thorough approach to record keeping and it is clear that they spoke with MCT and FCT about relevant risk factors associated with new born babies.

Child 'T' was born on 27 September 18 at Barnsley Hospital and discharged the following day, 28 September 18.

A midwife visited the family home the following day, 29 September 18, and conducted a check of the baby's bedroom and discussed safe sleeping, shaken baby syndrome, safe smoking. Child 'T' was stripped and examined.

A midwife visited on 30 September 18 due to Child 'T' being a first child for the parents and noted that he was slightly jaundiced. This is not an unusual situation for new born babies.

An additional visit was made the next day, 1 October 18, to check on the jaundice. At that time both parents and maternal grandmother (MGCT) were present.

Child 'T' was seen again by the Midwifery Service on 2 October 18 at a local centre for a routine blood test. It was noted that he was slightly jaundiced but this was not a cause for concern.

The last contact with the Midwifery Service was 8 October 18 when there were no concerns and Child 'T' was discharged.

At this point contact passed to Health Visitors employed by Public Health with the first visit taking place on 10 October 18. The Health Visitors, an experienced Health visitor accompanied by a Student Health Visitor, discussed a range of known risk factors with the parents who were both described as being very loving.

On 9 November 18, GP1 carried out a routine examination of Child 'T'. All new born babies are seen by a GP between six and eight weeks after birth. The primary purpose is to check for any congenital conditions but a thorough examination took place including examination of the, eyes, nose, mouth, abdomen etc. The baby is stripped for this examination. MCT did inform the GP1 that the baby was struggling to breathe through his nose when feeding; nasal drops were prescribed. The examination of Child 'T' did not raise any concerns. There were no signs of any injuries.

Other routine visits took place by Health Visitors.

On 28 November 18, Child 'T' was seen by GP 2 having been taken to the surgery by MCT and MGCT Maternal Grandmother Child T) for two issues. Child 'T' was described as being irritable and not feeding normally, only taking 3oz of feed rather than 5oz. He was also posseting after feeds. GP2 did not physically examine Child 'T'. The GP advised adding Gaviscon to his feed and gave a prescription. A discussion also took place about a potential change of milk with MCT being advised to discuss with Health Visitors (MCT did speak with a Health Visitor after the visit to the GP). The second issue was a skin tag on baby's ear which MCT wanted removing. There was nothing in the interaction between MCT and baby that concerned the GP.

It is understood that the post mortem examination of Child 'T' shows that he had fractures to the main bones in his left leg which pre date the ambulance call on 30 September 18. It would appear that Child 'T' had those fractures when seen by the GP2 on 28 September 18.

This raises the question as to whether or not this visit to GP2 was a missed opportunity to identify non accidental injuries prior to the day when he received injuries that led to his death.

It is important to remain objective and to avoid hind sight bias when conducting reviews.

This was the first presentation by MCT and MGCT of a baby who was reported not to be feeding normally and posseting. MCT and MGCT gave no cause for concern in their interactions with the baby and had brought it to see a Doctor at their own volition. There had been no concerns from any professionals about the family throughout the pregnancy or during Child T's tragically short life. Consequently, there was no information recorded that might have caused the GP to suspect that Child T was the subject of physical abuse.

Having discussed this situation with a Doctor who has a Safeguarding role within a Clinical Commissioning Group, it does not seem unreasonable for GP2 to have acted as they did, and that is to not conduct a full physical examination. The symptoms as described are consistent with reflux. A full examination was unlikely to discover the fractures. That said another GP may have chosen to examine the baby's abdomen despite that having happened just 19 days previously at the six week check.

This visit to the GP was the last occasion that Child 'T' was seen by a health professional prior to the ambulance call on 30 November 18.

5. Conclusions

This review has not found any concerns about the way that professionals worked with the family.

There were no obvious issues that would have suggested to staff working with the family that Child 'T' was at risk of abuse or neglect. Those professionals who met with the family and/or visited the home speak in positive terms of their interaction.

With the exception of the missed pre-birth visit by Health Visitors agencies did accord with their own policies and procedures. The author is satisfied that managers within Public Health and the Midwifery Service are taking action to resolve that communication issue and does not feel that it warrants a formal recommendation.

There is evidence of good practice in the record keeping by both Midwives and Health Visitors. Staff in both agencies kept comprehensive records that clearly evidenced assessments they completed and conversations they had with parents to discuss known risk factors to babies.

The National Child Safeguarding Practice Review Panel, that oversees the system of Serious Case Reviews and Child Safeguarding Practice reviews acknowledge in their guidance document published in April 2019[2] that children can be abused or neglected despite good work by professionals;

[2] Child Safeguarding Practice Review Panel: practice guidance, April 2019. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/793253/Practice_guidance_v_2.1.pdf

‘*we recognise that because of the nature of maltreatment, children may die or be seriously harmed even when practice is exemplary. And often despite the good work that is being done by practitioners’*

It is considered that this case is an example of such circumstances.

The only person/persons who have responsibility for Child T’s abuse and tragic death, is those that inflicted the non-accidental injuries. The police investigation will seek to identify them.