The Overview Report

into a

Serious Case Review of the Circumstances Concerning

Child A

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1. Introduction

1.1 Who was Child A?

1.1.1 Child A was born in Peterborough and her parents were Lithuanian nationals who had lived in the UK for 2 and 6 years respectively. It appears they came to the UK to seek employment, and there are extended family members also living in the Peterborough area.

1.1.2 The parents of Child A are among the 10.6% of the Peterborough population described as being 'White – other White'. 2% of those living in Peterborough are recorded as being born in Lithuania.

1.1.3 Child A was a healthy baby when she was born and the birth was normal although 9 days later than predicted. Her mother described her as a 'really good baby'

1.2 Brief Summary of Circumstances Leading to the Review

1.2.1 The case in question was triggered by the death of Child A. At about 11pm on Thursday September 5th 2013, Child A was taken to hospital by her parents. She was in a state of unconsciousness and all attempts at resuscitation failed. She died at 11.28pm.

1.2.2 Once a full examination had been conducted it was discovered that Child A had multiple injuries and the medical opinion was that the cause of the injuries was non-accidental. Child A died as a consequence of severe head injuries but other injuries she had also sustained included a significant number of cuts, bite marks and bruises to her head and face, further bruising to her chest, her back, left leg and left ankle as well as a torn frenulum.

1.2.3 A Serious Case Review is not concerned with establishing culpability however it is of note that the Crown Prosecution Service (CPS) authorised that Child A's father should be charged with the murder of Child A. In order to reach that conclusion, the CPS had to decide that there was a realistic prospect of conviction which was 'beyond reasonable doubt'. The analysis in this Overview Report is therefore firmly underpinned by a belief that Child A's fatal injuries were deliberately inflicted by her Father.

2. Process of the Review

2.0.1 On the 8th November 2013, the Independent Chair of the PSCB decided that a Serious Case Review was required under Section 4 of

the Statutory Guidance *Working Together to Safeguard Children* (2013).

2.0.2 Following the death of Child A, the designated paediatrician referred the death to the Independent Chair of the safeguarding board. This was followed up in keeping with the PSCB procedures with a formal referral from the hospital, the CDOP coordinator and the police. The PSCB then circulated the information to all partners in keeping with procedures to identify what information each of them may have on the child and the family. Following the receipt of that information, the Independent Chair made a decision in keeping with the requirements on him by Working Together to hold a SCR. This information was shared and the formal decision in relation to holding a SCR was made at the SCR panel meeting on the 8th of November 2013.

2.0.3 Working Together (2013) recommends that the decision to conduct an SCR should normally be made within one month of notification of the incident. It is recognised that the process outlined above meant that the commissioning of the SCR was slightly outside that timescale but this has had no detrimental effect on the learning achieved.

2.1 The Statutory Basis for Conducting a Serious Case Review

2.1.1 The role and function of a Local Safeguarding Children Board is set out in law by *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*. Regulation 5 requires the LSCB to undertake a review in accordance with guidance set out in Section 4 of Working Together to Safeguard Children (2013). The mandatory criteria for carrying out a Serious Case Review include where –

(a) abuse or neglect of a child is known or suspected; and

(b) either –

(i) the child has died; or

(ii) a child is seriously harmed and there are concerns about how organisations or professionals worked together to safeguard the child.

2.1.2 The product of the Review, known as the Overview Report, is sent to the Secretary of State for Children, and scrutinised by the Department for Education. All reviews of cases meeting the SCR criteria must result in a report which is published.

2.1.3 Revised *Statutory Guidance on Learning and Improvement* published by the Department for Education as a consultation draft in

June 2012, prescribed that SCR reports should be written with publication in mind and should not contain personal information relating to surviving children, family members or others. This includes detailed chronologies, family histories, genograms, or information known to organisations about the child and family members. Although that document has been superseded by the latest Working Together guidance, where possible, this Overview Report has been prepared within the spirit suggested and, whilst ensuring any lessons are learnt, every effort has been made to minimise distress for the surviving family members. Personal information about life within this family has been kept to the minimum required to provide a thorough and meaningful report into this review, although my analysis of practice benefited from a great deal of more detailed information contained within the agency reports, which are listed below.

2.1.4 Serious Case Reviews should be conducted in a way in 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; and
- Makes use of relevant research and case evidence to inform the findings

2.1.5 LSCBs may use any learning model which is consistent with these principles, including form of the systems methodology used in this case.

2.1.6 A key principle of the methodology is the engagement of frontline staff and first line managers in conjunction with members of LSCB Serious Case Review Panels or Subcommittees, Designated and Specialist Safeguarding staff, etc. The involvement of frontline staff and first line managers gives a much greater degree of ownership and therefore a much greater commitment to learning and dissemination.

2.1.7 This process is not about blame or any potential disciplinary action, but about an open and transparent learning from practice, in

order to improve inter-agency working. Importantly, it also highlights what is working well and patterns of good practice.

2.2 Independence

2.2.1 Working Together to Safeguard Children (2013) also mandates that 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. The LSCB should appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct reviews using the approach set out in this guidance. To ensure transparency, and to enhance public and family confidence in the process, the LSCB Chair appointed two independent people to lead this Serious Case Review.

2.2.2 In his document *Protection of Children in England: A Progress Report* Lord Laming (2009) expressed the view that in carrying out a Serious Case Review, it is important that the chairing and writing arrangements offer adequate scrutiny and challenge to all the agencies in a local area. For this reason, the chair of an SCR panel must be independent of all of those local agencies that were, or potentially could have been, involved in the case.

Mr Russell Wate QPM – Independent SCR Panel Chair

2.2.3 Mr Wate is the Independent Chair of Peterborough Safeguarding Children Board and was formerly the LSCB Chair in a London Borough.

2.2.4 He is supplied to Peterborough Safeguarding Children Board by RJW Associates who are independent safeguarding advisors.

2.2.5 He has had no case involvement and is totally independent of all agencies involved in this case and not employed by any of them.

2.2.6 He has a background from the police with a specialism in the investigation of homicide and childhood death in particular.

2.2.7 Mr Wate was responsible for independently chairing the various meetings connected with the review and ensuring that timescales were adhered to.

Dr John Fox MSc, PhD – Independent Overview Report Author

2.2.8 Dr Fox was responsible for drawing together all elements of the individual agency reviews, and for obtaining as much relevant information as possible from family members and significant others who might provide useful learning. He was responsible for analysing the professional practice of professionals and organisations and

making recommendations to the LSCB for further action to better safeguard children.

2.2.9 He has had no involvement directly or indirectly with the child or any members of the families concerned or the services delivered by any of the agencies. He has never worked for, or been affiliated with, any agency in Peterborough.

2.2.10 Dr Fox is a Senior Lecturer at the University of Portsmouth and previously was a police officer for 31 years including 8 years as a Detective Superintendent and Head of Child Abuse Investigation in the Hampshire Police. He sat as a member of 4 LSCBs and was Vice Chair of Hampshire ACPC.

2.2.11 He represented the Association of Chief Police Officers on various Government working parties and committees, concerning child abuse and related issues, including the drafting of the *Working Together to Safeguard Children* documents (1999, 2006, and 2013) and *Achieving Best Evidence in Criminal Proceedings*. He was Lord Laming's police advisor and assessor, on the Victoria Climbie Inquiry.

2.2.12 He has previously chaired Serious Case Review Panels, and is regularly commissioned as Overview Report Author by LSCBs. During the period when Ofsted were evaluating SCRs, all his reports were graded as outstanding or good.

2.3 Individual Agency Reports

2.3.1 Although Individual Management Reviews are no longer required under Government guidance, the process used during the current review includes individual agency reports.

2.3.2 The process requires that those conducting agency reviews of individual services should not have been directly concerned with the child or family, or given professional advice on the case, or be the immediate line manager of the practitioner(s) involved.

2.3.3 With the exception of the GP agency reviewer, the people preparing the individual agency reports for this Review were all senior personnel within each agency who were completely independent of any involvement or line management responsibilities concerning the case.

2.3.4 The SCR Panel decided that the following agencies and organisations would be asked to contribute to the learning of this Review.

Individual agency report provided by:
The Family GP Practice
Cambridgeshire Police
Peterborough Children's Services
Cambridgeshire and Peterborough NHS Foundation Trust
Peterborough & Stamford Hospitals NHS Foundation Trust

2.3.5 It was noted by Ofsted (2010) that the duties of the Overview Report Author include *'challenging the quality and content of individual agency reviews and ensuring that the overview report compensates for any identified deficiencies.'*

2.3.6 Collectively, the quality of the Agency Reports was sufficient for me to understand the case and provide an analysis of the significant issues.

2.3.7 It is of concern that the agency report written on behalf of General Medical Practice was written by the GP directly involved with the family. The GP acknowledged in his report that he was not independent of the case, but he did explain that he had only had one meeting with the child and that he had to do the report because he is the Safeguarding Lead for the practice. Clearly it has to be considered that this particular report lacks the necessary independence for the family and public to be confident in an impartial and transparent analysis of the facts. The LSCB should be concerned if the structure in Peterborough is such that it is not possible for an independent GP to carry out an internal agency review into primary care services.

2.4 The Practitioner Events

2.4.1 An initial scoping meeting was held at the beginning of the review process and this was followed by a briefing day for those professionals selected to write agency reports.

2.4.2 A Practitioners Learning Event was held on 10th February 2014 with over 14 attendees comprising agency authors, Designated and Specialist staff, LSCB Serious Case Review Subgroup, front line practitioners and their first line managers. A Recall Half-Day was held on 2nd April 2014 for all those who attended the Learning Day to consider and debate the first draft of this Overview Report.

2.4.3 Agency attendance at these events was generally very good. It is a matter of regret that although invitations were sent to three of their senior staff, no representative from Children's Services attended the Practitioners Event. A representative from Children's Services did attend the Recall event. The GP attended the practitioner event but not the recall event.

2.4.4 The Independent Chair for these meetings was assisted by the PSCB Business Manager and the PSCB Business Support Officer.

2.5 Scope and Terms of Reference

2.5.1 Time period: From the time of the first notification of pregnancy to Monday 9th September 2013 (the Monday following Child A's death).

2.5.2 The Terms of Reference specified the following 2 *'learning areas'* together with a requirement that these questions need to be covered by Agency authors and covered within the Overview Report.

- Did the family's migrant status act as a barrier, real or perceived, to access services that were available.
- Was the post death response by agencies effective and did agencies undertake it in line with agency and LSCB protocols.

2.6 The Voice of the Family and Significant Others

2.6.1 The Statutory Guidance requires that 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. A commitment to providing the fullest opportunity for individuals with a close connection to the family to be invited to participate in the review was agreed at the first scoping meeting.

2.6.2 In order to gain as much learning as possible from Child A's family, the Independent Panel Chair and Overview Report Author met with Child A's mother on 19th November 2013. On this occasion, she expressed a wish to participate in the review. She also expressed some of her views about services. An interpreter was present to assist communication.

2.6.3 Some of the mother's comments have been included in the analysis section below.

2.6.4 Child A's father is currently remanded in custody awaiting trial and at the request of the police it was decided not to seek an interview with him.

2.7 Individual Needs

2.7.1 The guidance in *Working Together to Safeguard Children* requires consideration to be given to individual needs - racial, cultural, linguistic and religious identity – of the child who is the subject of a Serious Case Review.

2.7.2 Although Child A was born in England, her parents and extended family are from a Lithuanian background. Child A was too young to be personally affected by any language barriers and her mother spoke English reasonably well although her father less well. Hospital records at the time of her pregnancy recorded that it had been identified from the New Pregnancy Referral Form completed by the mother that her main language was Lithuanian and she spoke "English a little bit". Therefore when the initial booking appointment was arranged it was identified that the mother would need an interpreter. When Child A's mother was interviewed in connection with the current review an interpreter was present although the mother indicated that she was able to speak and understand English fairly well.

2.7.3 As far as is known there was no evidence in the material that any issues of race, religion, language or culture affected events in this case or should have been significant in influencing the practice or approach taken to the delivery of services.

2.7.4 Although the family living conditions were cramped, both parents were in employment and there is no evidence of poverty within the family and there is no evidence in health records to suggest that this family experienced social or any other form of exclusion. It is reasonable to conclude that Child A had no individual special needs.

2.8 Accountability for the Overview Report

2.8.1 I attended the scoping meeting, and the Professionals Learning Event. Whereas I am accountable for the content and analysis within this Overview Report, the participants in the Learning Event and Recall Day have contributed to the process of the preparation and have offered helpful comments and suggestions during the drafting process.

3. The Facts - Summary of agency involvement

This section is designed to summarise the key relevant information that was known to the agencies and professionals involved about the parents, and the circumstances of the child. Since the Review is primarily concerned with Child A, only events which may have affected her, or the capacity for adults to look after her, have been included in this section.

3.1 Significant events prior to Child A's birth

3.1.1 On the 5th December 2012 Child A's mother had her first meeting with a midwife for an initial pregnancy booking appointment at the Veranda Children's Centre. A full history was undertaken which included review of the mother's medical, surgical, obstetric and social history. No risks were identified therefore the pregnancy was deemed as low risk, and ongoing care would be provided by a midwife.

3.2 Significant events during Child A's life

3.2.1 Child A was born on the 28th June 2013 hours at 20:50 by normal delivery. Although he had not been present during any antenatal appointments, Child A's father was present for the birth.

3.2.2 On 30th June 2013 Child A and her Mother were discharged from hospital with no recorded problems arising during the birth. At that time the mother was planning to breast feed.

3.2.3 On 11th July 2013, Child A was given a New Birth Assessment by a Health Visitor. It was recorded that her mother was *'doing well'* and *'no parental difficulties disclosed'*.

3.2.4 On 14th August 2013, Child A was seen at home by a Health Visitor for her 6 week development check. It was recorded, *'mum present throughout the visit. Child A is growing and developing well'*.

3.2.5 Child A was due to receive her immunisations on 28th August 2013 but she was not produced at the surgery and 'did not attend' was recorded in the notes.

3.2.6 On the morning of the 4th September 2013 Child A was taken to the baby clinic and received her first immunisations.

3.2.7 During the late evening of the 5th September 2013, Child A was taken to A&E apparently *'cold and lifeless'*. Child A was confirmed dead 23:28 hours.

4. A Day in the life of Child A and her family

4.01 Child A and her parents were initially living with relatives in a pleasant and well cared-for family home. Other resident family members were the mother's sister, the sister’s daughter and the mother’s brother (aunt, niece and uncle to child A). The parents of child A had their own large ground floor room as their bedroom and shared other facilities, but Child A's parents felt it was overcrowded.

4.02 After a short while they moved to another house which was shared with two other people. This was a 3 bedroom privately rented house and Child A and her family all lived in one room. Child A slept in a cot next to her parent’s bed. The family shared a bathroom and kitchen with the other two adult tenants.

4.03 As far as is known, Child A was loved and nurtured by her parents until the catastrophic attack on the day of her death. A Health Visitor had witnessed expressions of affection by mother and father towards Child A, and gentle tone and handling by mother at the 6-8 week developmental review.

5. Analysis of Key Episodes and the Lessons Learnt

5.01 In the short period covered by the Serious Case Review, Child A and her family had nothing more than routine contact with professionals.

5.02 Child A was provided with a universal health visiting service during the few weeks of her life and the health visiting team did not receive any information from any other agency that there were any safeguarding concerns for this child. The health visitors themselves expressed no concerns about Child A. In addition, Child A had attended the GP’s surgery on two occasions and there were no concerns noted about her health.

5.03 Whereas it was important that this review considered all aspects of Child A’s care, there was no evidence found by any professional of any maltreatment related injuries and therefore no reason why any professional should have raised concerns about her.

5.04 The remainder of this analysis section covers three key learning periods and will examine whether there was any reasonable possibility that an agency or individual professional could or should have been able to predict the events which occurred on 5th September 2013. The analysis will consider the case specific themes prescribed by the Terms of Reference

- Did the family's migrant status act as a barrier, real or perceived, to access services that were available.

- Was the post death response by agencies effective and did agencies undertake it in line with agency and LSCB protocols.

5.05 Both of these key issues are discussed during this section but the headline result of the analysis of the available information is that this Serious Case Review has revealed no evidence that during her life any agency or individual expressed any specific concerns for Child A's developmental milestones, health, wellbeing or upbringing. As a child she was 'visible' in the sense that she was seen appropriately by midwives, health visitors and her GP, as well as friends and family. There had been no safeguarding or 'child in need' referrals from any third party to Children's Services and she had never come to the notice of the police. No injuries, signs of neglect or other concerns which could reasonably have necessitated a safeguarding referral to Children's Social Care were noticed or recorded by any professional. Whether any signs of injury to Child A may have been missed is considered below.

5.1 Pre Birth and Maternity Unit Care

5.1.1 Child A's mother had self-referred to the GP regarding her pregnancy and was assessed to be a 'low risk'. The initial booking visit was undertaken with an interpreter but it was decided that her understanding of the English language was sufficient for future appointments to be carried out without the use of an interpreter. This is puzzling because the notes made at the time of booking clearly indicated that she was likely to need an interpreter by stating, '*her main language was Lithuanian and she spoke English a little bit'*.

5.1.2 During her interview with the Independent Reviewer, the mother confirmed that her understanding of English is reasonable but she said it would have helped her to have had an interpreter on other occasions as well. It has to be said however, that she appeared to the Independent Reviewer to be a very undemanding person, and at no time did she say asked for an interpreter or say to health professionals that she was unable to understand what was going on. There were occasions during the interview when the Reviewer felt the need to insist that the interpreter explained some of the more technical questions because he sensed that the mother was not fully cognisant.

5.1.3 This is a dilemma for professionals, particularly health professionals who are undoubtedly very busy. The learning point here is that when dealing with people for whom English is not their first language, it might be useful if to probe further about their understanding of English, and use an interpreter if there is any doubt.

However, in the current case under review, it is likely that Child A's mother indicated that she was able to understand to a sufficient degree, which she probably was in terms of all basic and necessary communication. It would perhaps have been more subtle and complex discussion which would have confused her, such as any questions about domestic violence, which she says she wasn't asked (although health professionals indicated that she was). This discrepancy may well be put down to a simple lack of understanding English sufficiently. There is no evidence of domestic abuse within the family and none was reported, but the point here is that there is a dispute between what the health professionals say they asked and what the mother says she was asked. It is reasonable therefore to consider that the mothers' level of English did not allow her to understand some of the things she was being asked.

5.1.4 There was therefore documentation in the notes with regards to a 'language barrier' but when interviewed by the Agency Reviewers the midwife could not recall there being any communication barriers between herself and the mother. This resulted in there being no further request and use for translator services from any health professional. The key learning being developed here is that even when a client doesn't ask for extra assistance, a professional needs to consider the possibility that they just 'don't want to make a fuss' and if that is the case, extra assistance should be considered anyway on behalf of the child (who doesn't have a voice). The point here is that the primary, and most vulnerable client is the child, and it is important for the child that her mother fully understands what is being said to her by professionals so sometimes the professionals may need to act on behalf of the child even if the mother is not requesting particular assistance.

5.1.5 During her interview with the Independent Reviewer, it was stated by the mother that the father of Child A did not speak English well. Any communication with him would therefore probably have required an interpreter. It was noted in health records that the father had not attended any antenatal appointments but in her interview with the Independent Reviewer, the mother confirmed that he had in fact attended but was not spoken to by any professional. In view of this claim by the mother, the Midwife has been spoken to again and reaffirmed her belief that the father did not attend any appointments.

5.1.6 This anomaly cannot be resolved by this review but if it was the case that he was present, there should have been some attempt to engage with him and ascertain whether he would be a primary carer for the child. As far as is known to the current review there is nothing of any concern recorded about the father in any agency records so even if he had been spoken to, or even if his own health service records had been checked, there would have been no reason to identify him as a risk to child A. It is noted in the GP Report that as

the father was not a patient at the family GP Practice, *'it may be that we were therefore less aware of his background and any pathology or illness in him that may have affected the family dynamics'*. This report goes on to suggest, *'further assessment of the father with retrospect might have been helpful'.*

5.1.7 As a point of principle, it is important that midwives and health visitors do what they can to become aware of male figures within the family, and if they are visibly present at appointments to try and engage with them in conversation. Although it is a commonly held view that in the professional relationship with midwives and health visitors the mother and child are the 'clients', since the primary, and most vulnerable, client in any new birth is the baby, it seems unacceptable that the fullest information about her primary caregivers is not routinely sought.

5.1.8 The Midwives Rules and Standards (2012) seem to support this proposition. In fact, whilst certainly emphasising the relationship between mother and child, that national document also reminds midwives, '*You must make sure the needs of the woman and her baby are the primary focus of your practice and you should work in partnership with the woman and her family*'. Clearly the known father of a child is part of the mothers' family and therefore the national guidance for midwives suggests that they should also work in partnership with him and perhaps on a practical level to at least ascertain if he needs any support or advice. Since there were no medical notes available through the GP it was even more important in this case for health professionals to have a conversation with him to ascertain whether there was cause for further enquiry into what support he may need.

5.1.9 In his 2009 report, Lord Laming firmly reminded us about the role of fathers within parenthood. He stressed, *'parenthood incorporates not only rights but also responsibilities: it is a lifetime commitment. Particular mention should be made of the part to be played by fathers.'* The spirit of this comment seems to be that with fatherhood should come an acceptance that one's own personal rights to privacy will be subordinate to the responsibility that one's child is properly safeguarded. This was also a theme recognised by Brandon et al (2009) in one of the Biennial Analysis Reports of Serious Case Reviews:

> *"The failure to know about or take account of men in the household was a theme in a number of serious case reviews. Assessments and support plans tended to focus on the mother's problems in caring for her children and paid little attention to the men in the household and the risks of harm they might pose to the children given histories of domestic violence or allegations of or convictions for sexual abuse."* (Brandon et al, 2009)

5.1.10 At the SCR professionals learning event it was explained that health questions were asked at every trimester, but the focus was on the mother, looking at her medical history, but also considering social history including criminality, housing and domestic abuse. It was confirmed by health professionals present that appropriate questions were asked although as mentioned above the mother does not recall that she was asked about domestic violence. It is noted in the hospital Agency Report that an *'outline enquiry relating to Domestic Abuse was undertaken by MW1 at the initial booking appointment. In the Personal Pregnancy Record there is no further evidence to confirm that routine enquiry was made later in the mother's pregnancy. During the interview with Midwife1 routine enquiry was explored, Midwife1 confirmed that routine enquiry was made at booking but has appeared to be omitted in later pregnancy.'*

5.1.11 It was also noted at the learning event that other than one appointment the same midwife was engaging with the family throughout the pregnancy and this was considered as a positive by the professionals at the learning event because it is likely to have given the mother more confidence and peace of mind. Indeed, it is worth noting here that the mother was very complimentary about the midwifery service and the fact that she had the same midwife throughout the whole pregnancy might have contributed to that feeling.

5.1.12 Following a normal pregnancy, Child A was born 9 days overdue. The Father was present at the birth and the mother was keen to go home and was discharged. It is noted in the Hospital Agency report that whilst on the inpatient ward Child A and her mother received appropriate support and information relating to breastfeeding. This report also pointed out that Peterborough and Stamford Hospitals NHS Trust Maternity Services has received UNICEF level three baby friendly Initiative accreditation. This evidences that the service is giving a good quality of breastfeeding support. Maternity staff, including Maternity Support Workers, receive regular mandatory training in relation to breastfeeding. Peterborough City Hospital also offers an additional service, where all breastfeeding mothers are contacted following transfer home from hospital by a breastfeeding peer support worker to discuss breastfeeding and offer additional support if required.

5.1.13 Child A's feeding pattern was described by midwives as normal and midwives had encouraged the mother to stay another night to help establish breastfeeding and build her confidence in relation to breastfeeding prior to transfer home. During her interview with the Independent Reviewer the mother confirmed that she stayed an extra night in hospital but she feels she would have benefitted from extra help in understanding how to breastfeed her child as before long she

had trouble producing enough milk and had to revert to bottle feeding.

5.1.14 There is no suggestion from her that this caused any extra stress or tension within the household, so this overview report does not take the position that Child A was in any way compromised by a failure in communication. It is indeed likely that the mother did not ask midwives or health visitors for any extra help, but as noted above, when seen by the Independent Reviewer she certainly gave the impression that she was very un-demanding. The interpretation of the criteria '*if required*' as highlighted in paragraph 5.1.11 above needs careful consideration by the NHS Trust. It is important to try and establish when such an un-demanding mother is, in fact, in need of support, even when she does not express clearly that she requires it.

5.1.15 It is possibly a relevant factor that the feeding assessment in the postnatal care plan was not completed by midwifery staff. The aim of this feeding assessment is to ensure adequate feeding prior to discharge and provide information on access to feeding support in the community, and if this had been completed as is usually the case it may have prompted the mother to seek further help. At the learning event it was suggested that the Health Visitor did not ask if she wanted to breastfeed *'as mum was already bottle feeding and some women may feel guilty if they are told to breastfeed'.*

5.1.16 Information relating to feeding support that is available following transfer from hospital and in the community is available in the Personal Health Record for Child A which was given to the mother. However, the written material, (including the 'bounty packs' and a breastfeeding leaflet which was given to the mother) was all written in English and the mother had difficulty fully understanding the literature.

5.1.17 It is suggested that the NHS trust uses the learning opportunity from this case to examine, and if necessary improve, the availability of communication in the key languages which correspond with the population mix in its catchment area, and the LSCB should seek reassurance that this is done. **RECOMMENDATION**

5.1.18 Following transfer from hospital Child A and her mother received appropriate postnatal care. The first and second postnatal visit was undertaken by the same midwife and the last visit was undertaken by the midwife who had provided all the antenatal care.
Child A was seen by a Maternity Support Worker on the 5th Day and all usual actions were taken. There is documentation of relevant monitoring undertaken and consistent health advice given.

5.1.19 When interviewed for the current review, Child A's mother was very complimentary about all the health staff who provided a service both during the antenatal stage and birthing stage. She said the nurses were 'really good' and that during the birth there was no problem and the midwives were 'very nice'.

5.1.20 She also commented that Child A was a 'really happy baby'. She just cried twice and was a 'really good baby'.

5.2 The transition to Primary Care and the 6 week check

5.2.1 At the post mortem examination it was confirmed by a Home Office Pathologist that Child A had suffered multiple injuries including biting, trauma to the abdomen as well as the serious head injuries which led to her death. It is a necessary part of this review to consider whether any of those injuries are now known to have been present at the time of the various medical appointments post birth, and if so to ascertain as far as possible whether it was reasonable that they were not detected. The evidence from pathologists provided to the current review does not indicate that there were any injuries which predated the day of her death. The rest of this analytical section therefore adopts the position that no health professional had any reason, through their physical examinations, to be concerned for the wellbeing of Child A.

5.2.2 At 11:00 am on 30th June 2013, Child A and her mother were transferred home from the Inpatient ward at Peterborough City Hospital by a midwife. A home visit was conducted by a midwife two days after the discharge and it was noted that *'mother is well, with no concerns raised'*. Child A was examined and apart from some jaundice, she also appeared well.

5.2.3 National guidance indicates that a primary birth visit by a health visitor should take place no later than the 14th day after birth. In the event, a home visit to see Child A was arranged for 11th July 2013. Child A was 13 days old.

5.2.4 The health visitor carrying out this check is a registered Adult Nurse, and was in her final period of 'consolidated practice' as a student Health Visitor at the time. She was qualified and experienced enough to carry out this check.

5.2.5 A routine 6-8 week developmental review was conducted by the same health visitor at home on 14th August 2014. The Health Visitor had the opportunity to speak to the mother alone and it was recorded that there were no apparent indicators of vulnerability or issues which raised cause for concern about the health and well-being or Child A or the parents' capacity to care for the child. According to the mother,

the health visitor undressed the child and did all the 'handling' herself.

5.2.6 Child A was taken to the GP surgery on 21st August 2013 and she received a 6 week check by her family doctor. It is noted in the GP Report that, *'as always the baby was examined taking all clothes off except the nappy, and a full developmental examination of the baby was made on the couch and was normal. As always, the examiner would check for signs of NAI which there were none of'. The mother was not depressed.'*

5.2.7 It appears then that Child A was seen appropriately by a midwife, a health visitor and a doctor at various times during her short life. The child was undressed and carefully examined by these experienced health professionals and nothing of any concern was noted.

5.2.8 On the 28th August 2013, Child A was due to be taken to the GP surgery for her first immunisations. The family failed to attend but this may have been due to the fact that they had recently moved from the sister's house to the new rented accommodation and it is possible the appointment letter may have gone astray. Either way, there is nothing particularly significant about this non attendance for a single appointment.

5.2.9 Child A was subsequently brought to the surgery by her father on 4th September 2013 for the immunisations. Once called to the treatment room for her immunisations the baby's father declined to hold her and a nurse therefore held Child A on her lap, gently holding her hands whilst another nurse gently held her legs together whilst the practice nurse gave the oral rotarix and the GP gave immunisations into Child A's left and right thigh. The father stayed in the treatment room throughout.

5.2.10 It was noted by staff at the GP Practice that Child A was clean and well dressed with a modern clean pushchair. There were no signs of accidental injury although only the baby's legs were exposed and visible for the injections. The father was clean in appearance and appeared calm. The GP Report Author considers it not unusual for a parent to decline to hold their baby and does sometimes happen if a parent has a needle phobia.

5.3 The admission to A&E and Rapid Response Process

5.3.1 At 22:59 hours on 5th September 2013, child A was brought into the Emergency Department at Peterborough City Hospital by her mother and father. Her heart had stopped and she was not breathing. Resuscitation was attempted by a large team within the emergency

department, but this was unsuccessful and she was pronounced dead at 23:28 hours.

5.3.2 When, in 2003, three high profile criminal convictions involving the prosecution of mothers for causing the deaths of their babies were overturned by the Court of Appeal, The Royal College of Pathologists and The Royal College of Paediatrics and Child Health asked Baroness Helena Kennedy QC to chair an intercollegiate working group to review how sudden deaths in infancy should be investigated. The subsequent report published in 2004, made several recommendations which were used by the Government to form the basis of the statutory guidance in *Working Together to Safeguard Children* (2006) and which stated a *'multi-professional approach is required to ensure collaboration among all involved'.* Each LSCB was thereafter encouraged to produce a local protocol, based upon the statutory guidelines in *Working Together*, to enhance inter-agency co-operation in SUDC investigations. The current edition of *Working Together to Safeguard Children* (2013) also requires that a child death protocol exists in each LSCB.

5.3.3 Peterborough LSCB produced such a protocol and it is known as the *Cambridgeshire & Peterborough CDOP Multi Agency Protocol for the Management of Unexpected Childhood Deaths*. This protocol was firmly embedded into the safeguarding training and fabric of the LSCB procedural material by the time Child A died in September 2013. Peterborough and Stamford Hospitals NHS Foundation Trust and Cambridgeshire Police have signed up to the protocol and so employees working for both those agencies are expected to adhere to it.

5.3.4 As soon as Child A arrived in the Emergency Department a Nurse took her into the resuscitation area. The Nurse noted bruises on Child A's forehead which she documented. It was immediately clear to medical staff therefore that they were dealing with a child who had suspicious injuries.

5.3.5 It is documented that after Child A had been examined by doctors on duty in the Emergency Department, a more senior doctor, a Consultant Paediatrician was called out from home. It was not until this senior doctor arrived that the hospital contacted the statutory safeguarding agencies. The Consultant Paediatrician examined child A's body and noted several bruises and superficial cuts over the head in particular. He documented that the bruises and cuts are suspicious of non-accidental injury and he informed the parents that the police, coroner and social services were to be contacted and that there were procedures that needed to be followed. He then contacted Children's Social Care (CSC) Emergency Duty team at 00:20 hours and he informed the Police at 00:35 hours.

5.3.6 It is a matter of concern to the Independent Reviewer that it was not until 90 minutes after the admission, and one hour after death was pronounced, that the police were informed. The police rely on a prompt referral of suspected child homicide in order to ensure important evidence is secured and in some cases to ensure the safety of surviving siblings (although in this case that was not an issue). It is important to note however that according to the Police Agency Report, '*despite this delay this appears to have had no effect on the immediate and continuing response by the police or other agencies*'.

5.3.7 This systems review is concerned with establishing why such a delay might have occurred and it appears that there is a rigidity about the seniority level of the doctor who is allowed to inform the police of a suspicious death. It was explained at the practitioners learning event that in this case, the on-call Consultant Paediatrician was called but had to travel from home several miles away so it took a while for him to arrive. According to the Hospital Agency Report the Consultant Paediatrician arrived at the hospital at 00:15 hours however, at the Practitioners Recall Event this version of events was updated and the author for the Hospital Report felt he had arrived before resuscitation had concluded. What is clear is that it was only after that more senior doctor arrived that a call to the police was made, and this was about 90 minutes after A&E staff had first noted bruising to the baby's head. As stated above the Police were happy with this procedure.

5.3.8 The main point of learning here is that Peterborough Hospital Emergency Department staff should not have to wait for the arrival of an on-call doctor from outside the hospital before discharging their safeguarding responsibilities. Many professionals are expected to use their judgement to report suspected child abuse. This includes for example, teachers, nursery workers and GP's, and *Working Together to Safeguard Children* (2013) encourages the notion that, *'Anyone who has concerns about a child's welfare should make a referral to local authority children's social care'.* It is the view of the Independent Reviewer that if a doctor in the Emergency Department is charged with the responsibility to resuscitate an injured child, they should also be allowed the option of contacting the police when they have suspicion that a crime may have been committed. Whilst in this case the delay appears to have had no detrimental effect, in other cases it might.

5.3.9 The *Cambridgeshire & Peterborough CDOP Multi Agency Protocol for the Management of Unexpected Childhood Deaths* seems to support this view in the following passages:

> Para 2.2 *"...should there be **any** suspicion a child has died from an unlawful act, then the presumption shall be that the child's body and the place of death are both crime scenes. These will*

need to be secured pending the arrival of a Police Senior Investigating Officer. Whilst every effort will always be made to resuscitate a child, if it is clear no medical intervention can help, the crime scenes must be secured as soon as possible. If a criminal act is suspected, immediate consideration must be given to whether or not there are other children e.g. siblings who may require safeguarding and a referral made to children's social care."

5.3.10 The words "as soon as possible" and "immediate" figure prominently in this section. It is recognised that there are many priorities for medical staff when a seriously ill child is admitted to the Emergency Department. However, other agencies are relying on a prompt referral in order to carry out their statutory duties and it is difficult to accept accept that 67 minutes after the child was pronounced dead or 96 minutes after abuse was first suspected can be considered to be "immediate".

5.3.11 Later, the same Policy states:

Para 3.3 - Hospital Staff in Emergency Department: *"If there are suspicions that the child died from an unlawful act, immediate consideration should be given to the need to safeguard any remaining siblings and Social Care must be contacted immediately."*

In this case there were early suspicions as soon as the child was brought in to the Emergency Department that the child had died from an unlawful act, but Social Care were not contacted immediately.

5.3.12 The LSCB should seek clarification from Peterborough & Stamford Hospitals NHS Foundation Trust that there are no local arrangements in place in respect of which level of doctor can make a referral, which potentially builds in a delay in inter agency safeguarding referrals, and thus delays the opportunity for other agencies to quickly commence their safeguarding responsibilities. **RECOMMENDATION**

5.3.13 It is noted in the Hospital Agency Report that the on-call paediatric consultant *'took a history from the parents at 00:15'*. Since this was 45 minutes after death was pronounced, and presumably after the doctor had concluded that the child was a potential victim of homicide, it is the view of the Independent Reviewer that this 'history taking' should ideally have been taken after there had been a discussion with the police. This is to avoid further delay in notifying the police and to avoid the possibility that the parent's statements might be contaminated by information given to them by medical staff. It is clearly appropriate that if resuscitation is being attempted there will need to be urgent discussion with the parents of a sick

child, but once a child has died and the death is considered to be suspicious, it is better for any detailed history taking to be done in conjunction with police officers. The health members on the panel felt that the medical history taking still should take place by the consultant paediatrician to form a view on NAI. This is accepted, but in this particular case, NAI was already suspected and therefore it would have been helpful for the police to have had the opportunity to take part in the 'history taking'.

5.3.14 It is important that the family are offered appropriate support by medical staff, and it is important to urgently establish whether there are any other children in the household, but this is distinct from the detailed questioning by a doctor about the circumstances surrounding the collapse, which apparently took place at 00:15 hours on 6th September.

5.3.15 However, by taking the history from the parents the Consultant Paediatrician was complying with the PSCB *Policy for the Sudden Death of a Child* and this overview report does not criticise him in any way for taking the history.

5.3.16 It is the view of the Independent Reviewer that in certain respects the Policy is confusing and should be reviewed. In particular, Section 3.4 is not helpful because it instructs the doctor to take a history from the parents and examine the child but does not mention that this should be done with the police if they are present at the hospital or on their way there. In the earlier paragraph (3.3), it does say that if the parents attend the Emergency Department with the dead child, the history taking should be done *"by the senior clinician in conjunction with the police"* so these two sections are inconsistent and confusing because they give different messages about police involvement depending on whether the ambulance brings in the child or the parents bring in the child.

5.3.17 It is suggested that the Policy is reviewed and the following two bullet points which appear in Paragraph 3.4 are both amended to include the words, 'in conjunction with the Police lead investigator if possible'

- A senior doctor should take a detailed and careful history of events leading up to and immediately prior to death.

- A thorough examination of the body by a senior doctor must take place with the examination findings recorded on a body chart (including any post mortem changes)

5.3.18 Having received the call, and in accordance with child death protocols, a number of police officers including supervisory officers attended the hospital in response to the notification. This included the

attendance of the night shift senior detective, Detective Inspector rank, identified as PO1, and a Detective Sergeant identified as PO2. Both of the officers are experienced members of the public protection department and have experience of dealing with matters pertaining to child abuse, child deaths and domestic abuse.

5.3.19 The leading police officer, having discussed the case with medical staff, decided that the death was indeed suspicious, and a homicide investigation was commenced. This was carried out promptly and effectively and both parents were arrested on suspicion of murder.

5.3.20 When there has been an unexpected childhood death, there is a requirement under *Working Together to Safeguard Children* (2013) for the lead clinician to *initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and local authority children's social care) to decide what should happen next and who will do it*. This should normally be held within the first few hours after a death but certainly within 24 hours. It is evident in this case that no such meeting was held.

5.3.21 It is stated in the Police Agency Report that professionals including health and social care professionals, agreed that the police would take 'primacy'. Although it is correct to say that the police should lead on the criminal investigation, it is the view of the Independent Reviewer that the normal 'rapid response' multi agency meetings should still take place. This is so even when it seems to be clear that a death is a criminal act and due to child abuse. There are cases when in fact an initially suspicious looking death turns out to be from natural causes and so it is important that professionals keep an open mind and continue the multi agency quest to establish how and why the child died.

5.3.22 The *Cambridgeshire & Peterborough CDOP Multi Agency Protocol for the Management of Unexpected Childhood Deaths* is quite clear that there is a requirement to continue to have the Rapid Response meetings even when criminal investigation is ongoing.

> *"Information sharing is vital, therefore the appropriate health professional, Police and Social Care participate in an Initial Case Management Discussion, within 12 hours of the death being confirmed....*
>
> *Where there is a criminal investigation initiated the sharing and disclosure of information remains a key element in the process of the investigation into the child's death and the meeting should still be held face to face with detailed minutes being taken."*

5.3.23 There is no problem with the procedures therefore but for reasons which were not established by the current review they were not followed by the 'rapid response' process. The LSCB should seek reassurance by way of an audit of the timings and meetings that take place as part of the child death procedures. **RECOMMENDATION**

6. Conclusions and Summary of what has been learnt

6.01 The death of Child A could not reasonably have been predicted by any agency or individual who knew her or had any information about her. This Serious Case Review concludes that no professional, nor any family member, had any child protection concerns for Child A during the period covered by the review.

6.02 It is an example of good practice that the midwives provided a consistent service to the family by ensuring that a single professional conducted nearly all the interaction during the antenatal period.

6.03 There is some confusion over whether the mother needed additional support from an interpreter during her interaction with health professionals. The mother states that she would have found this useful yet it appears that health professionals were unaware of this requirement and apart from the initial booking appointment, no interpreter was engaged. In addition, all documentation given to the mother was in English which she found difficult to understand.

6.04 It appears that no attempt was made by midwives or health visitors to engage with Child A's father either during the antenatal, birth, or post birth period. As someone who was clearly visible and identified as a primary carer, more should have been done to communicate with him and ascertain if he required any support.

6.05 The family GP's input into Child A's life, as well as the life of the family as a whole, was appropriate and the GP and other health professionals received a great deal of praise from the mother for her support and health care.

6.06 There was no evidence of any error by medical professionals in respect of the 6 week check. The evidence from a pathologist did not indicate that any injuries predated the day of Child A's death. It is noteworthy that the health visitor personally undressed and handled the child and is therefore highly unlikely that any injuries were present at that time and lend support to the likelihood that Child A died as a result of a single and unforeseen attack on the day she was taken to the Emergency Department.

6.07 When Child A was presented at the Emergency Department on the day of her death, the immediate procedures, emergency response, and support for the family were all carried out in an appropriate and professional manner. There was a delay in informing the police of the death and this appears to have been caused because it is seen as necessary for a Consultant Paediatrician to be called in to the before a formal referral to the police can be made. The police were content that they were being informed by a knowledgeable person in this case that allowed them to make appropriate and informed decisions.

6.08 The police response to the incident was led at the appropriate level of rank and expertise. The case was quickly identified by doctors and the police as a suspicious death and a homicide investigation was commenced promptly and professionally.

7. Recommendations for Peterborough SCB

These recommendations should be read in conjunction with the Action Plan which provides detail about methods of implementation and timescales.

Recommendation 1

The PSCB should seek reassurance from the Peterborough & Stamford Hospitals NHS Foundation Trust that key information is available, and is distributed, in the main languages which correspond with the population mix in its catchment area.

Recommendation 2

The PSCB should seek clarification that that Police and other agencies are notified as soon as possible in regards to all Sudden Unexpected Childhood Deaths and that there is no practice or procedure which could potentially create a delay in making such a referral.

Recommendation 3

The PSCB should seek reassurance, by way of quality assurance activity that the timings and meetings that take place as part of the initial information sharing and planning discussions as part of the Child Death Procedures are fully compliant with Working Together 2013 and the protocols.

Recommendation 4

The Cambridgeshire & Peterborough CDOP Multi Agency Protocol for the Management of Unexpected Childhood Deaths (August 2012) is reviewed by a task and finish group from both Cambridgeshire and Peterborough LSCBs.

List of References

Brandon et al, (2009) *Understanding Serious Case Reviews and their Impact - A Biennial Analysis of Serious Case Reviews 2005 – 07*: London, DCSF

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