SERIOUS CASE REVIEW
IN RESPECT OF BABY A

EXECUTIVE SUMMARY
AND REVISED ACTION PLANS

October 2012
Updated May 2013
1. **INTRODUCTION**

1.1 Baby A was a child from Gateshead who died at the age of 10 weeks. His death was caused by a head injury. Subsequent tests indicated a number of injuries including a fractured skull, a subdural haemorrhage, retinal haemorrhage, a fractured arm, rib fractures and a number of bruises. The injuries were considered by medical staff and the police to be non-accidental.

1.2 Baby A was born in Tyne and Wear. His parents, Miss A and Mr B, had separated during the pregnancy and Miss A had started a new relationship with Mr C whilst pregnant.

1.3 Following his discharge from hospital Baby A lived in Gateshead all of his life. He was too young to be considered to have a first language or religion however the first language of all of his family is English. Baby A had no recorded physical disabilities.

1.4 Miss A and Mr C were both questioned in relation to Baby A’s death. Both initially denied causing the injuries to Baby A, however during court proceedings in relation to Baby A’s murder, Mr C admitted shaking Baby A when he would not stop crying, but denied intending to kill him. Mr C was found guilty in court of Baby A’s murder and Miss A was found guilty of causing or allowing his death.

1.5 When a child dies and abuse or neglect is suspected, the Local Safeguarding Children Board (LSCB) has a statutory responsibility to carry out a review of the case in order for any learning to be identified about the way that agencies worked with the family. This is known as a serious case review. The purpose of a serious case review is not to identify who killed the child but whether or not agencies working with the family could have done things differently.

1.6 A serious case review involves a series of meetings between independent people and senior managers from all of the services who work with children and their families in the area. The whole process is overseen by a panel of senior managers, called a Serious Case Review Panel. The result of a serious case review is a series of single agency reports, called individual management reviews (IMRs), a detailed overview report and this report, called an executive summary. At the end of the process all of the reports are submitted to Ofsted for evaluation and the Department for Education (DfE) for information.

1.7 The serious case review was completed in line with Chapter 8 of *Working Together to Safeguard Children* (2010). Following the conclusion of the Ofsted evaluation and any criminal or related proceedings in the case
there is a requirement for LSCBs to publish both the executive summary and the anonymised overview report. **NB the serious case review process has now changed and, as of 5 July 2012, there is no longer a statutory requirement for LSCBs to submit serious case reviews to Ofsted for evaluation.**

1.8 In the serious case review with respect to Baby A the Serious Case Review Panel was independently chaired by Sue Taylor, a barrister who specialises in family law. The overview report and executive summary were originally written by Barry Raynes, who is the chief executive of Reconstruct, a consultancy company providing services to child care agencies throughout the UK.

1.9 The Serious Case Review Panel consisted of:

Sue Taylor – Independent Chair

Area Manager – Central Gateshead Council

Designated Nurse – Safeguarding Gateshead Primary Care Trust

Designated Doctor – Safeguarding Gateshead Health NHS Foundation Trust

Detective Inspector – Gateshead Northumbria Police Public Protection Unit

Head of Litigation Gateshead Council

Head of Offender Management Northumbria Probation Trust

Head of Service – Children, Families and Young Offenders Service Gateshead Council

LSCB Business Manager

Service Manager – Safer Communities Team Gateshead Council

Service Manager – Safeguarding, Quality and Improvement Gateshead Council

1.10 IMR reports were prepared by a number of services in Gateshead Council, including Children’s Social Care, Northumbria Police, health agencies in Gateshead, including both acute and community services, and also a
health agency based outside of Gateshead where Miss A and Baby A had accessed services.

1.11 The Serious Case Review Panel established Terms of Reference which identified the main questions which needed to be addressed. The timeframe for the review covered a period from a date in 2010 (which was around the time that Baby A was conceived) until the date he was admitted to hospital with injuries in 2011 and also took account of the backgrounds of the adults involved.

1.12 Some members of Baby A’s family (who were not suspects in the investigation into his death) were invited to participate in the process however they decided that they did not want to be involved. Because Baby A’s mother was the suspect in an ongoing investigation into his death while the serious case review was underway she was not invited to take part but was notified via her solicitor that her son’s case was the subject of a review.

1.13 Baby A’s father was offered the opportunity to hear the findings of this serious case review prior to publication.

1.14 Following an evaluation by Ofsted, additional Terms of Reference, overview report and a revised executive summary (this document) were written by the Practice Review Sub Group of Gateshead LSCB. The two overview reports and executive summary will be published following the conclusion of the police investigation into Baby A’s death and the subsequent criminal trial.

2. SUMMARY OF EVENTS

2.1 Miss A was aged 18 at the time of Baby A’s birth and had separated from Baby A’s father during the pregnancy. She subsequently began a relationship with a new partner, Mr C, who later moved in with her and Baby A. Following the breakdown of the relationship with Mr B, Miss A told some professionals that there had been some violence in their relationship.

2.2 As a young child, Miss A and one of her siblings had been involved with health and social work professionals due to concerns regarding neglect. The family later left the Gateshead area before returning when Miss A was a teenager.

2.3 Miss A had reportedly experienced abuse during her childhood from a member of the extended family and also had a history of depression. Miss A later disclosed these issues to her midwife during her pregnancy and her midwife felt that, as the problems were in the past, she did not need
any extra support. As a consequence, the midwife did not complete a fuller assessment which might have concluded that there were some factors in Miss A’s history which meant that any child she had may be vulnerable and that she would indeed benefit from additional support. Miss A also told her midwife after she had separated from Mr B that he had been violent towards her. Again, because the midwife felt these issues were in the past, she chose not to carry out any further risk assessment around Miss A and her unborn baby.

2.4 There was also no referral made to the Family Nurse Partnership programme in respect of Miss A and her unborn child by the midwife. The programme is a service for all first-time teenage mothers in Gateshead which provides further support until the baby’s second birthday. Miss A would have qualified for this programme as she was aged under 20.

2.5 Miss A was seen for routine midwifery appointments before she gave birth to Baby A. Professionals were aware of the breakdown of her relationship with Mr B and took steps to ensure that she felt safe during her appointments, however no additional antenatal risk assessments were carried out.

2.6 Miss A and her new partner Mr C were involved in a car accident whilst she was pregnant. They both attended hospital and neither were found to be seriously injured. Tests were also carried out on the unborn baby and no concerns were noted.

2.7 Baby A was born just over three weeks early. He was initially well but required medical support a few hours after his birth and needed a stay in hospital for just over a week. While he was receiving treatment in hospital professionals also shared the previous concerns about Miss A and Mr B’s relationship.

2.8 Miss A and Baby A saw various professionals (Early Years workers, doctors and health visitors) on 12 occasions in the weeks following his discharge from hospital. There were no concerns expressed about Miss A’s care of Baby A and many professionals commented positively about her care. Mr B had weekly contact with Baby A which was supervised by Miss A’s family.

2.9 Baby A attended his GP practice for a routine 6-8 week development check. He was initially seen by a health care assistant who was concerned as she noted two small marks on his face, which she described as bruises. The health care assistant was also concerned that Miss A appeared to change her explanation for these marks and had also said that “my baby bruises easily”, “even when just being held”. The health
care assistant asked Miss A whether this was because Baby A was being roughly handled, but she denied that this was the case.

2.10 The health care assistant decided that she would speak to the GP who was scheduled to see Baby A as part of the check, prior to the appointment. The GP thoroughly examined Baby A in line with usual practice for a 6-8 week check but found nothing of concern. The GP was satisfied with Miss A’s explanation of events and the marks on Baby A’s face, which he described as marks and not bruises, and recorded that no bruises were seen.

2.11 Baby A’s health visitor visited him the following day for a scheduled home visit. At that stage the health visitor was unaware of the health care assistant’s concerns and spent 90 minutes in the address with Baby A, Miss A and Mr C and discussed a range of issues. The health visitor did not notice any marks on Baby A. Miss A informed her that Baby A bruised easily. The health visitor was reassured as Miss A stated that she had told the GP about this.

2.12 The health care assistant continued to be worried about Baby A and discussed the issue with the practice nurses in the GP practice who advised her to contact the baby’s health visitor. It took a further seven days before the health care assistant and the health visitor were able to discuss the issue as they were both very busy. Following the discussion the health visitor also spoke to the GP and they decided that she should speak to Miss A about the concerns and any other issues. They agreed to do this on a specific date when Miss A was expected to come to a drop-in clinic with Baby A, however she did not attend as expected.

2.13 Miss A and Baby A attended a baby clinic at another clinic a week after the health visitor’s home visit. Baby A was seen by another health visitor and was weighed and given immunisations. No concerns were identified.

2.14 Several days later, and six days before Baby A’s death, Miss A took Baby A to the A&E department of a local hospital as she was worried that he was vomiting and had a cold. He was thoroughly examined by a doctor who could find nothing seriously wrong and prescribed infant Gaviscon.

2.15 A few days later Baby A was brought into the A&E department of a local hospital by ambulance. When the ambulance had arrived at the home address Baby A had no pulse and was not breathing for himself. He was later transferred to another hospital and sadly died the following day.
3. **KEY EVENTS AND ISSUES**

3.1 The aims of the serious case review, in line with Chapter 8 of *Working Together to Safeguard Children* (2010), were:

- to establish whether there are lessons to be learned from the case and the way in which local professionals and agencies work together to safeguard and promote the welfare of children
- to identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result of the review outcomes
- to improve interagency and intra-agency working and better safeguard and promote the welfare of children

3.2 The Serious Case Review Panel identified three key events and considered these in detail. They were:

- the decision by the community midwife not to complete a more detailed assessment
- the events at the GP practice when Baby A attended for a 6-8 week check
- the examination of Baby A by the doctor at A&E six days before the death

3.3 The original Terms of Reference for the serious case review were judged by Ofsted to provide a framework for the majority of the issues in relation to the case but were found to be insufficiently specific in relation to two key matters; practice relating to non-mobile babies presented to professionals with facial or other unusual injuries and processes to identify all adult family members and their role within the family.

3.4 The revised overview report therefore also considered:

- whether practice, decision making and procedures relating to non-mobile babies presenting to professionals with facial or other unusual injuries were appropriate
- whether processes were in place to identify all adult family members, their role within the family and whether or not they posed a threat to a new born baby because of their respective histories.

4. **FINDINGS OF THE SERIOUS CASE REVIEW**

4.1 **Historical involvement**

4.1.1 Miss A’s history shows a number of areas of vulnerability. There is no information recorded to suggest that Miss A was living in Gateshead when the alleged abuse occurred or where in the country she was actually living
(as the family moved around on a number of occasions) or whether this was reported to the police and local Children’s Social Care. Miss A accessed counselling services in Gateshead in her teens when the family returned to the area, and she should have been questioned further so that her history was clearer.

4.1.2 Mr C also had input from professionals during his childhood and lived with his grandmother from an early age. Mr B and his family had limited contact with a number of professionals during his childhood. This was not analysed in depth for the purposes of the serious case review as it was not judged to be relevant.

4.1.3 By the time Miss A and Mr C became a couple he was already the father to a one-year old daughter and no concerns had ever been raised about his parenting. He was viewed by both professionals and his ex-partner to be caring and appropriate towards his daughter.

4.2 Involvement with the family while Miss A was pregnant

4.2.1 There were at least two occasions where Miss A was seen by her midwife when there were indications of an additional level of vulnerability which should have triggered further risk assessment (which would have in turn triggered further safeguards).

4.2.2 Miss A’s history shows a number of areas of vulnerability. In isolation these historical concerns would not necessarily lead professionals to be concerned about any potential risks to Baby A, however when viewed in combination with the alleged concerns about Miss A and Mr B’s relationship and other vulnerability factors surrounding Miss A. This should have led to more detailed risk assessments of the pregnancy being carried out.

4.2.3 The Serious Case Review Panel agreed that Miss A and her unborn baby met the criteria for further support and it would have been appropriate for the community midwife to ensure that this would happen by completing an additional risk assessment known as an AN2. The midwife chose not to do this as she felt that Miss A’s problems were in the past and judged her to be a confident young woman.

4.2.4 If an AN2 assessment had been completed in relation to Miss A and her unborn baby then the GP, health visitor and health care assistant would have been aware that there was a level of vulnerability in Miss A’s background and additional concerns. Whilst this would not have highlighted sufficient enough concerns to start child protection procedures, this may have made other professionals more sensitive to the possibility that Baby A could be at risk.
4.2.5 Miss A should also have been referred to the Family Nurse Partnership for additional support as a young first time mother.

4.3 Involvement with the family after Baby A’s birth

4.3.1 The main area that the Serious Case Review Panel considered was the events of the 6-8 week check at the GP practice. The health care assistant was worried about Baby A as she saw marks which she thought to be bruises and was not comfortable with Miss A’s explanation. The GP carried out a thorough examination of Baby A and did not find any bruises on his body. He noted two small marks on Baby A’s face which he did not think were bruises and later stated that he only saw these as health care assistant pointed them out. He was satisfied with Miss A’s explanation and decided that there was no need for further explanation.

4.3.2 The GP was able to reassure the IMR author who reviewed his practice that he would be able to respond appropriately if he had indeed found bruising to Baby A’s face or head. There are clear procedures in place in Gateshead for managing cases where unusual or suspected non-accidental injuries are found in children, particularly bruising in non-mobile babies. The GP stated in interview that he would have followed these procedures had he been at all concerned that Baby A had bruises to his face and/or head and/or was displaying signs or symptoms of abuse. To date the GP is still clear that there were no bruises on Baby A when he examined him.

4.3.3 Professionals continued to discuss the health care assistant’s concerns after this date. Unfortunately there were delays in professionals speaking to each other about this and no one was able to challenge Miss A further about the concerns. Unfortunately Baby A died before the health visitor was able to speak to Miss A about the marks/bruises and her previous comments.

4.3.4 Baby A was thoroughly examined in A&E a few days before his death when he presented with cold symptoms and vomiting. The doctor in A&E saw no bruises on Baby A’s body and found no reason to be concerned enough to order further tests or discuss him with other colleagues.

4.3.5 The post mortem examination carried out after Baby A’s death showed that whilst his head injury was caused during a single incident shortly before his admission to hospital, some of his other injuries were older (but could not be dated precisely). It remains unclear whether Baby A had any fractures when he was seen in A&E that evening but the doctor saw nothing in Baby A’s presentation that would warrant an x-ray or other form of imaging.
4.3.6 The Serious Case Review Panel discussed whether or not the doctor took the correct course of action. The IMR report author who examined the doctor’s practice found it to be appropriate. It would be highly inappropriate to conduct x-rays or CT scans on babies presenting to an A&E department where this was not indicated, as was the case with Baby A on this occasion. The IMR author and Serious Case Review Panel were satisfied that, had the doctor been concerned that Baby A was injured, she would have followed the correct procedures from both a clinical and safeguarding perspective.

4.3.7 Throughout this case it is clear that that no one agency or practitioner had a true full understanding of Baby A’s living arrangements and the history of all of the adults with whom he was in contact with. Key practitioners should have asked Miss A more detailed questions about her and Baby A’s living arrangements and about those people who Baby A was having significant contact with during his short life.

5. CONCLUSION

5.1 All serious case reviews are conducted with the benefit of hindsight and inevitably identify areas for improvement. Whilst the serious case review identified some areas where practice could and should have been different it is unlikely that Baby A’s death could have been predicted or prevented and it can not be attributed to the failings of any one professional or agency or the way that agencies in Gateshead worked together.

5.2 The Serious Case Review Panel examined the case of Baby A and found that, on the whole, inter-agency working and individual working was sound. There were occasions when professionals were required to use their judgement to determine whether to view this case as one of concern and, with hindsight, some of these professionals could have made different decisions.

5.3 The Serious Case Review Panel were provided with a number of examples of good practice where agencies worked well together and there are appropriate procedures in place to safeguard children and young people in Gateshead. There were, however, occasions where some professionals used their own judgement and felt that there were not enough concerns to follow additional procedures e.g. the midwife’s decision not to complete an AN2 risk assessment and the GP decision not to respond to Baby A’s marks/bruises and Miss A’s comments as a concern.
5.4 Lessons have been learned in this serious case review in relation to:

- documentation and record keeping
- understanding a family’s circumstances
- antenatal risk assessment and some professionals’ understanding of guidance and available pathways
- managing bruising in non-mobile babies and listening to what parents say in addition to a child’s physical presentation
- the serious case review process itself

5.5 Recommendations were made in a number of the IMR reports, the original overview report and the revised overview report. These are detailed below and in the action plan.

6. RECOMMENDATIONS FOR ACTION

6.1 Additional recommendations

6.1.1 The LSCB Policy and Procedures Sub Group should revise the Gateshead LSCB Serious Case Review Procedures in line with new guidance within three months of the publication of the revised *Working Together to Safeguard Children*. The revised local procedures should contain a requirement that serious case reviews should not be signed off by the LSCB or submitted to Ofsted/DfE until post mortem examinations have been completed, regardless of whether this is set out in the new statutory guidance or not.

**Action lead/responsible person:** Joanna White, Chair of LSCB Policy and Procedures Sub Group

**Timescale:** High (three months from the date of publication of the revised *Working Together to Safeguard Children*)

6.1.2 Guidance for completing AN1 and AN2 forms should be revised to include a requirement to discuss the unborn child in supervision.

**Action lead/responsible person:** Judith Corrigan, Named Nurse, Safeguarding Children

**Timescale:** High (0-3 months)

6.1.3 Guidance for completing AN1 and AN2 forms should be revised to include a requirement to share completed AN2 forms with the mother’s (and unborn child’s) GP practice.

**Action lead/responsible person:** Judith Corrigan, Named Nurse, Safeguarding Children

**Timescale:** High (0-3 months)
6.1.4 Guidance should be developed so that GP practice are able to flag cases where an unborn child has been the subject of an AN2 risk assessment in a similar way to cases that are flagged when a child is subject to a child protection plan etc.

**Action lead/responsible person:** Brian Liddle, Named GP, Safeguarding Children  
**Timescale:** High (0-3 months)

6.1.5 Guidance should be developed so that GPs can use body maps to document injuries and marks to children. The body maps and guidance should be easily accessible to GPs on the GIN portal.

**Action lead/responsible person:** Brian Liddle, Named GP, Safeguarding Children  
**Timescale:** High (0-3 months)

### Original Overview Report recommendations

1. The chair of the LSCB should write to the Director of Patient Safety, SOTW Community Health Services, to request that NICE safeguarding guidelines *When to suspect child maltreatment (2009)* be adopted by all GP practices.

2. The chair of the LSCB should write to the Director of Patient Safety, SOTW Community Health Services, to stress the need for a Named GP for safeguarding to be appointed and to seek assurances about interim arrangements.

3. Gateshead Clinical Commissioning Group should ensure that a safeguarding link post (a GP) in each practice is enhanced as outlined in the "safeguarding GP toolkit".

4. All GP practices in Gateshead should be able to identify that safeguarding standards are being met in GP practices.

5. Gateshead LSCB Inter-Agency Child Protection Procedures should reinforce the importance to healthcare professionals of listening to parents and taking appropriate action to ensure that children are safeguarded.

6. Gateshead Health NHS Foundation Trust should ensure that all families who are eligible for the Family Nurse Partnership scheme are routinely referred.

7. Gateshead Health NHS Foundation Trust should ensure that A&E staff are aware of the previous attendances of all babies under 1 year of age.

8. Newcastle NHS Hospitals NHS Foundation Trust should ensure that all healthcare professionals in maternity services are aware of male partners when working with families.

9. SOTW Community Health Services (Gateshead PCT) should ensure that information is shared with a child’s named health visitor when pre-school children are seen by GATDOC.

10. SOTW Community Health Services (Gateshead PCT) should establish a protocol for the GP led Well Baby Clinics, which identifies the Healthcare Assistant Role and competencies.

### Single agency recommendations

1. Gateshead Council Early Years Service should ensure that staff are consistent in the way they deal with and record concerns about children.

2. Gateshead Council Early Years Service should ensure that child protection issues are addressed in supervision.

3. Gateshead Council Early Years Service should ensure that all staff and visitors are aware of their responsibilities for safeguarding.
4. Gateshead Council Children’s Services should ensure that the social work therapy team are aware of their client’s full history.

5. Gateshead Council Children’s Services should ensure that any disclosure of abuse or violence made within a therapy session is responded to appropriately.

6. Gateshead Health NHS Foundation Trust should consider whether it is appropriate for junior medical staff in A&E to discharge children without senior overview.

7. Gateshead Health NHS Foundation Trust should ensure that all letters generated by the coding department should reflect accurate information.

8. Gateshead Health NHS Foundation Trust should ensure that record keeping within the maternity department is accurate and comprehensive.

9. Gateshead Health NHS Foundation Trust should ensure that all midwifery staff record appropriate safeguarding information.

10. Gateshead Clinical Commissioning Group should ensure their safeguarding link post (a GP) is enhanced in each practice as outlined in the “Safeguarding GP toolkit”.

11. The safeguarding audit for GPs on standards of safeguarding practice must be completed.

12. The Associate Director for Quality and Patient Safety will write to the chair of the LSCB requesting that the LSCB Inter-Agency Child Protection Procedures make explicit the importance of GPs listening to parents.

13. The Newcastle upon Tyne Hospitals NHS Foundation Trust should ensure that all healthcare professionals in maternity services are aware of male partners when working with families.

14. Gateshead PCT should implement guidance and thresholds of information received in Antenatal Vulnerability forms (AN1/AN2) for health visitors.

15. Gateshead PCT should develop level 3 training for health visitors relating to bruising/marks in non-mobile babies.

NB. No recommendations were made to Northumbria Police in either their IMR report or the Overview Report.