West Sussex

Safeguarding Children Board

Serious Case Review

Report

Baby T

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1 INTRODUCTION

1.1 This serious case review was commissioned by West Sussex Safeguarding Children Board following the death of a baby, known throughout this review as Baby T. Baby T died in a regional hospital in 2017 of injuries which were thought at the time to be suggestive of non-accidental injury. He was 10 weeks old and lived with his parents.

1.2 Baby T's mother had called an ambulance after Father had alerted her that Baby T was unresponsive and had stopped breathing. Baby T was taken to a local hospital and on the same day transferred to the regional paediatric intensive care unit. Investigations confirmed that Baby T was suffering from severe retinal bleeding and bleeding on the brain, injuries which were identified at the time as potentially being caused by shaking and/or impact. Baby T subsequently died of his injuries.

1.3 Statutory guidance[1] at the time required Local Safeguarding Children Boards to carry out a serious case review when a child has died, and abuse and neglect are known or suspected. The death of Baby T fulfilled the criteria for a serious case review and the previous Chair of West Sussex Safeguarding Children Board commissioned this review.

1.4 An independent lead reviewer and serious case review panel made up of senior managers from agencies within West Sussex were appointed. The first phase of the review took place in parallel with police enquiries. Family members were informed that the review was taking place but were not offered an opportunity to contribute, pending decision by the Crown Prosecution Service as to whether any member of the family would be charged with an offence.

1.5 During the initial phase of the review, further forensic reports confirmed the traumatic nature of Baby T's injuries and that they must have been as a result of considerable force. It was also suggested the injuries may have occurred over a period of time and later forensic examination confirmed that Baby T had suffered two events causing injury, one several days prior to death and another closer to the time of death. A decision was made to prosecute Baby T's father and he was convicted of Manslaughter and Grievous Bodily Harm and received a custodial sentence.

2 REVIEW PROCESS

2.1 The primary questions agreed for the review by the LSCB Case Review Group and amended at the first serious case review panel meeting were:

- For the agencies involved with this child and family, what was the quality and effectiveness of the response in recognising and responding to vulnerability factors? How well did this inform any assessment and intervention?
- To what extent did professional curiosity inform assessment and intervention?

[1] Department for Education (2015) *Working Together to Safeguard Children* Page 75-6

- How was information used and shared to inform assessment and intervention and were there any barriers to sharing information?
- What are the similarities with any findings and themes from recent serious case reviews in West Sussex (N, O and S) and what is the relevance of these for the findings and recommendations of this review.

2.2 Chronologies/ reports of involvement were received from:

- Sussex Police
- Primary Care Services (GPs)
- Sussex Community NHS Foundation Trust
- Western Sussex Hospitals NHS Foundation Trust
- South East Coast Ambulance Service
- The Regional Paediatric Intensive Care Unit.

2.3 It was agreed that the lead reviewer should meet with practitioners who had contact with the family along with the relevant chronology author.

2.4 Meetings took place with:

- Consultant Paediatrician at the local hospital
- GP
- Health Visitor
- Midwife

2.5 Whilst waiting for the conclusion of the criminal proceedings an interim report was presented to the LSCB in order that any immediate learning could be considered, and action taken. Following conclusion of the proceedings Baby T's mother (known as "Mother" throughout this report) was offered an opportunity to contribute to the review. She agreed to do so and met with the lead reviewer and chair of the panel and we are very grateful for her helpful observations. Father was also offered the opportunity to contribute and spoke to the chair of the panel.

3 FAMILY BACKGROUND

3.1 There is nothing within any agency records indicating any vulnerabilities within the background of Baby T's mother or father.

3.2 Mother comes from a local family who were considered by practitioners to be supportive. Father had moved to West Sussex from another area and this review has received no information indicating any vulnerabilities in his history. Mother and Father lived together in well maintained, privately rented accommodation.

4 INVOLVEMENT WITH SERVICES IN WEST SUSSEX

4.1 Up until the death of Baby T there had been no involvement with the family other than routine services.

4.2 In August 2016, Mother was pregnant, saw the GP and was referred to the midwife.

4.3 Mother was seen at home by the midwife at eight weeks and six days gestation. This booking appointment was not carried out by the usual midwife due to the usual midwives' maternity leave and records show that Father was present at the booking appointment. It is expected practice that midwives ask fathers about their alcohol use, smoking, employment and whether they have other children. It has not been possible to confirm from the records whether Mother was asked if she had ever felt threatened or vulnerable, but again this would be expected practice. When the usual midwife picked up Mother's care at 16 weeks gestation, no concerns were passed on either verbally or in the records.

4.4 Midwifery care was unremarkable, and it was good practice that Mother saw the same named midwife from 16-week gestation onwards. All parents are offered an ante-natal class on a Saturday focused on birth and labour and in addition there is a two-hour "Baby Matters" class on a weekday. This was attended by Mother and included information on:

- Breast feeding & hand expressing
- The first 10 days and what to expect emotionally and physically for both mum & baby
- Five to thrive and brain development
- Safe sleeping
- How to deal with crying and unsettled babies
- Who will visit & when they will visit
- Who the maternity support workers are & the support they will provide.

4.5 Mother also recalls attending the Saturday morning class with Father and that this mainly focused on practical matters such as bathing the baby. Father remembers attending a class and hearing about crying babies, different cries and being told not to shake or shout at the baby.

4.6 Baby T was born in 2017. Emergency procedures were followed for shoulder dystocia[2] but examinations by midwife and paediatrician post-birth found the baby to be in good condition. Shoulder dystocia is a relatively common occurrence and midwives would be very familiar with the procedures necessary to assist the birth. An appointment was made with the physiotherapist, as is usual practice.

4.7 Baby T was visited at home in line with usual practice by the community midwife. The midwife recalls that the final visit (with a student midwife) on day 11 was "textbook" and very thorough. Both parents were seen, and no concerns noted. Baby T was seen the same day by the health visitor and noted to be gaining weight and doing well.

4.8 The health visitor has told the review that she understood Mother and Father to be in a stable relationship and both parents were very welcoming at the new birth visit. The health visitor described Father as physically strong and Mother as quiet, unassuming,

[2] Where the baby's shoulders become stuck

but confident. There were no concerns at either the new birth visit, the baby clinic or the six-week contact. The six-week contact took place in the family home with Mother and included all the expected advice, including prevention of sudden infant death, feeding and general health promotion. The usual enquiries were also made about maternal mental health and domestic abuse.

4.9 It was expected practice that there should be a discussion with the health visitor about managing crying and avoiding hurting your baby, although Mother does not recall this being discussed at that visit[3]. Within West Sussex the Integrated Prevention and Earliest Help Service[4] promote 'Five to Thrive' which is a social modelling tool promoting attachment and the underlying workbooks discuss support with a crying baby. Health visitors are also being trained in the use of promotional guides, which also contain specific reference to crying babies and each practitioner has access to a reference copy of the NSPCC 'Coping with Crying' leaflet.

4.10 In June 2017, Mother called the GP surgery and described Baby T as being unwell for 14 hours – vomiting, one wet nappy, red eye, floppy, reduced oral intake. Mother was advised to take baby into the GP surgery which she did 35 minutes later. The GP provisionally diagnosed bronchiolitis and appropriately referred Baby T to the paediatric department at the local hospital.

4.11 One doctor at the hospital recalls Father getting cross about not being seen quickly enough (which was not felt to be justified) but this was not significant enough to be documented in the records. Baby T was admitted to the ward and both Mother and Father stayed with him overnight. He was found to be suffering from a childhood illness and was discharged home with open access to the hospital for the next 72 hours and advice on "red flag" features was given.

4.12 Three days later, Mother and Maternal Grandmother took Baby T back to the assessment unit at St Richard's hospital due to concerns about the way he was feeding, and he was admitted to the ward. Father joined Mother in the ward later in the day. During examinations Baby T was also found to have a (non-significant) heart murmur. There is nothing of concern in the nursing notes. The review was told that nurses would have documented if they had any concerns about any rough handling or the parents were particularly anxious about crying.

4.13 Baby T was discharged home the next day. Mother has told the review that from her perspective she would have liked the opportunity to give one more feed before discharge and felt that they were being sent home due to pressure on beds. This is not the perspective of the hospital and it is impossible to verify either account. Even if this was not the intention of the hospital to ask Mother to go home before she felt ready, it is important to understand that this is how Mother recalls feeling at the time. She also does not recall being told about the heart murmur and feels that she should have received a letter about this and a follow up visit from a health professional.

[3] The recent core descriptor in the health promotion guidance clearly states a requirement to discuss crying babies. Page 29 of the Personal Child Health Record lists crying babies as a discussion point at the new birth visit and there is a field to complete on the new birth visit template.

[4] This was the name of the service at the time of this review, it is now known as Early Help

4.14 Nine days after his discharge from hospital, at 13.01, Mother called the ambulance describing Baby T as in cardiac arrest. The history given was that Mother had fed him at approximately 12.00 and Father then tried to settle him in his vibrating chair. Father had noticed that his eyes had rolled back, he was unresponsive and had stopped breathing and called Mother. Baby T was taken to the local hospital where, because of the seriousness of his condition, he was transferred to the Regional Hospital paediatric intensive care. At this stage the paediatrician believed that Baby T would be unlikely to survive but the transfer to the regional hospital would allow further investigations to take place and would give the family time to adjust.

4.15 The paediatrician at the local hospital recalls Father asking on more than one occasion whether they knew what had caused the injury. This was unusual behaviour of a parent in these circumstances. There was little time to take a full history at the local hospital and a more detailed medical history was obtained by the intensive care team from the regional paediatric intensive care unit.

4.16 The paediatrician from the local hospital had suspected possible non-accidental injury and when she heard about the retinal haemorrhaging she was not surprised. With hindsight she feels that she could have been clearer about her suspicions with the police when concerns about Baby T were first raised, as the police were not treating the injuries as suspicious at that stage.

4.17 Baby T died of his injuries the next day and Sussex Police began their investigation.

5 FINDINGS

Finding One
Preparation for parenthood needs to provide adequate opportunity for both parents to learn about the practical *and* emotional aspects of caring for a new-born baby and access adequate advice and support as and when this becomes necessary.

5.1 No vulnerability factors were obvious and in fact, the case history outlines generally good care from community health services.

- There was continuity of midwifery care, midwives work closely with GPs and are located within the GP surgery.
- Health visitors are also located within the GP surgery. There are monthly meetings between GPs and health visitors where there is an opportunity to discuss any concerns about families registered with the surgery.
- All antenatal and postnatal checks were completed with opportunities to see both parents in the family home.
- There is the offer of one antenatal and one baby matters class.

5.2 It is less clear to what extent *both* parents are routinely given the opportunity to discuss in any depth how to manage when babies cry and the prevention of abusive head injury. The Baby Matters sessions provide little opportunity for this as they cover several topics in a short space of time and are held on a weekday when fathers are unlikely to attend. The weekend class focuses on practical issues and only

Father recalls managing crying being mentioned. The Lead Reviewer has been told that practice has now developed and managing crying is now promoted as a vital aspect of health promotion. Health visitors are expected to discuss this at the new birth visit. It will be important to make sure that discussion of this sensitive topic is being embedded into day to day practice across all partner agencies as appropriate.

5.3 One way in which new parents may be offered advice and support is via children and family centres. As noted in a previous serious case review within West Sussex[5], this provision is actively promoted, and health visitors are charged with asking parents at ante natal and pre-birth visits whether they would like to be registered with their local centre and assisting them with registration. The take up rate for this service is 85%.[6] . However, there is no centre within the town where Baby T lived, and the nearest centre is not easily accessible on public transport. This would not have been thought of as a cause for concern in this case as the extended family lived locally and were understood to be very supportive.

5.4 Within West Sussex, "Family Assist" has been developed which may have been helpful in a situation where either parent was worried about caring safety for a young baby. Family Assist is an online communication and information tool and has the potential to deliver public health messages to women and families from pregnancy to 19 years. Family Assist can be used universally as it has two functions; one is the delivery of timed and relevant public health messages to those registered; the other is a web-based information platform available to all. It is promoted by the Healthy Child Programme across the county but maternity providers other than those in the west of the county have not yet signed up to the service so in those areas it is only accessed after the birth.

5.5 Women and those they wish to nominate (importantly fathers) can sign up at booking with a midwife and from then the system generates e-mail communication relevant to the age of the child. It is possible to see whether e-mails have been opened and to target information as needed. The system includes a live chat function which enables families to ask for advice before difficulties escalate. In this case it may be that such a system would have provided additional advice and support although Mother was unsure whether Father would have accessed such a tool had it been available at that time.

5.6 As a result of a serious case review[7], a new initiative within Hampshire addresses the topic of abusive head trauma and Hampshire are promoting the roll out of ICON, a whole system approach to preventing abusive head trauma, nationally[8]. This is a programme of intervention based around coping with crying and is based on research into abusive head trauma which shows that crying is a known trigger, 70% of perpetrators are males and incidents increase in the first month of life with a peak at six weeks and a decrease during three to six months. These factors would seem to

[5] West Sussex LSCB Serious Case Review Baby O
[6] West Sussex Child and Families Centres Management Report 2017
[7] Hampshire LSCB serious case review Baby U
[8] https://www.hampshiresafeguardingchildrenboard.org.uk/toolkits/abusive-head-trauma/overview/

be relevant to this case. The programme requires the same messages being shared with parents and carers at different stages by different professionals and has now been taken forward by West Sussex Safeguarding Partnership as a means of extending their on-line provision. They have also included "DadPad"[9] which is specifically targeted as a support to fathers.

Recommendation One

The West Sussex Safeguarding Partnership should continue to develop a whole system approach to the prevention of abusive head trauma and evaluate progress of the tools (ICON and DadPad) that are being implemented to develop this.

Finding Two

It is good clinical practice to consider the possibility of non-accidental injury when a baby is taken to hospital with symptoms that might indicate they have been harmed. Vomiting is one symptom that should prompt this analysis.

5.7 It is important to stress that this is not a case where there were obvious missed signs and symptoms when Baby T was taken to hospital two weeks prior to the serious incident. It is only as a result of the forensic post-mortem, that we are aware that there was an injury that predated his death.

5.8 There is however nothing in the records to indicate that non-accidental injury had been considered and discounted. This would have been good practice and consideration of both medical and social factors should automatically be included in the analysis and recorded in the hospital notes.

Recommendation Two

Medical/health professionals should ensure that medical assessments where a baby presents with any symptoms associated with non-accidental head injury/abusive head trauma (NAHI) include a clearly documented analysis considering the possibility of NAHI. NAHI should be considered as an important cause of babies presenting with any of the following features - apnoea, seizures, vomiting, irritability/drowsiness and reduced feeding, even in the absence of any external injury.

[9] https://thedadpad.co.uk/

6 CONCLUSION

6.1 There is nothing to suggest that the severe injuries to Baby T could have been predicted. There were no obvious signs that would have indicated that this was a vulnerable family who may need help beyond the services that would be offered to all new parents. Services were delivered to expected standards and community services exceed those found in other areas of England with, for example, one named midwife caring for the mother throughout pregnancy. There are opportunities at the local surgery for GPs, midwives and health visitors to communicate about vulnerable families, all visits expected by the Healthy Child Programme took place and the family and baby were seen within the home environment.

6.2 There are opportunities to develop support services to all new parents including a specific focus on managing babies when they cry. There are also opportunities to make sure that support reaches fathers and these services are currently being developed within West Sussex.

6.3 There was an opportunity to improve documentation in hospital when Baby T was admitted with vomiting and other symptoms indicative of usual childhood illnesses. This does not show that non-accidental injury was actively considered and discounted. Although conclusions and treatment may have been the same, this is an area for practice improvement.