BEXLEY SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW - BABY F

D.O.B: 01/01/2012
D.O.D: 14/06/2012

Independent Overview Report.

Author: Oena Windibank
Post: Independent Consultant
Date: **July 2013**

CONTENTS

1 INTRODUCTION

1.1 This Overview report summarises the findings of the Serious Case R review undertaken into the death of Baby F. In accordance with Working Together 2010 * and Working Together 2013* the report seeks to analyse the events that occurred and to identify lessons that can be learnt by the LSCB and the agencies involved.

1.2 The SCR panel has undertaken a robust process of reviewing the involvement of all the agencies involved in the life of Baby F including in the antenatal period. In accordance with Working Together 2010/13 the SCR panel was chaired by an Independent Chair and this Overview Report is authored by a separate Independent Author.

1.3 Baby F died unexpectedly aged five months in June 2012. The cause of his death was determined at the post mortem to be due to Florid Rickets caused by severe vitamin D deficiency and this deficiency was also identified as the causation for severe growth failure. Rickets is an unusual and rare preventable illness

1.4 The skeletal survey revealed severe metabolic bone disease, multiple healing rib fractures, a spiral fracture of the left humerus and possible fractures of the metatarsal and metacarpal bones. These were consistent with florid rickets and severe skeletal hypo mineralisation, there were no signs of non-accidental injury.

1.5 Baby F was born in Hospital on the 1.1.12 to Mr and Mrs F, both parents are of African origin and have strongly held religious beliefs. Mrs F is a housewife and Mr F was an adult respiratory nurse at the time of these events. Baby F was their only child.

1.6 Mrs F booked for antenatal care late at 28 weeks at the GP practice during a GP new patient booking appointment. During the antenatal period Mrs F had refused an ultra sound scan and nutritional supplements advised due to mother's strict vegan diet and ethnicity. Specific advice on the need for Vitamin D supplements was not given when nutritional supplements were discussed. Mrs F did however accept HIV testing on the advice of a relative.

1.7 At Birth Baby F was generally well although small for his gestational age (presenting with Inter Uterine Growth retardation, IUGR) however shortly after birth Baby F was admitted to SCBU where he was treated for jaundice, respiratory problems, hypoglycaemia and bleeding in the brain.

1.8 During this period his parents initially refused medical treatment for him which had been advised by his paediatric consultant, their continuing refusal led to the hospital making a referral of child protection concern to children's social care. Consent was given to treatment; it is believed that Mr and Mrs F's strongly held religious beliefs led to their initial refusal for treatment.

1.9 Following Baby F's discharge from hospital there was a joint home visit by the social worker and health visitor and subsequently he was seen by the health visiting service, however his parents did not take him to two follow up hospital appointments, his 8 week check or commence his immunisations. He was not seen again by any agency from the 29th of February 2012 until his death on 14.06.12.

1.10 Baby F's parents reported to police after his death that he had had a cough since April, he had been unwell for a few days and was not feeding properly. His parents did not seek any medical assistance or advice with regard to his deteriorating symptoms, they reported that they were aware he was ill but were awaiting 'a sign from God' with regard to seeking help or treatment.

1.11 The police were called to the family home on the 14th June by the parents stating that their son 'had no sign of life' and he was sadly subsequently pronounced dead in hospital at 19.12 pm.

1.12 Mr and Mrs F were charged by the police with manslaughter and neglect on 7th March 2013. They both pleaded guilty to manslaughter in January 2014 and are due to be sentenced on 28 February 2014.

2.0 Methodology

2.1 The CDOP recommended to the SCR panel on 6th September 2012 that a serious case review be actioned in this case. The Independent Chair of the Safeguarding Children Board took the decision to undertake a serious case Review on the 28.12.2012.

2.2 An independent chair was appointed on 02.01.2013.

2.3 An Independent author was appointed on 02.01.2013.

2.4 The SCR panel comprised of representation from all agencies across the area and has reviewed all agency IMRs, requesting additional information/clarity as required.

2.5 IMR reports have been completed by all agencies involved in the care of Baby F, this includes;

- Children's social care.
- Primary care,
- Community Health services.
- Secondary care including midwifery services. these are noted in the report as Acute Trust 1 (Antenatal and post natal care)and Acute trust 2. (post death care)
- The local Clinical Commissioning Group (CCG).
- Police.
- Faith organisation.

- The Ambulance service did not complete an IMR but were interviewed as part of the Health Overview report.

2.6 Annexed to the report is the action plan which includes recommendations from this review and the individual recommendations made by each agency. The agencies involved have reviewed all the actions as part of the Serious case review panel to ensure they meet the lessons learnt contained within the report.

2.7 Baby F's parents were informed by the Independent chair of the SCR including its purpose to identify lessons learnt in relation to the services provided. They were invited to participate in the process however their legal representatives have declined the offer on their behalf due to impending legal proceedings.

2.8 The SCR was commissioned late December 2012 and four formal panels meetings took place with a number of clarification sessions in between. The final overview report is to be agreed by the LSCB core panel in July 2013 and presented to the LSCB in November 2013. Publication of the review will be dictated by the legal proceedings.

2.9 The review has considered research, local and national guidance and Policy and recent SCRs within the area to inform its analysis.

3. Terms of reference

3.1 To establish the facts of the case in relation to what was known to each agency in respect of 'Baby F' and his parents within the period between January 2011 and 1st January 2013. (Additional relevant information about the mother and father of 'Baby F' outside of this time frame should also be considered);

3.2 Consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken, which indicate that practice or management could improve, try to get an understanding not only of what happened but why.

3.3 Were Baby F's needs appropriately identified, assessed and responded to? Were any risks to him appropriately identified? To what extent did agencies identify safeguarding concerns in relation to Baby F, in particular in relation to neglect?

3.4 Did assessments and services provided to the family take sufficient account of their race, culture, language, and religious needs, and any disability needs and how were these needs met? Did they examine the voice of the child and in what ways this was considered?

3.5 What was life like for Baby F? It is essential that his daily life experiences and an understanding of his welfare are at the centre of the SCR (Working Together, 2010, 8.1);

3.6 To what extent were the concerns for Baby F by different professionals given weight and acted on?

3.7 To what extent, if any, was professional optimism a factor?

3.8 How did inter agency communication and working together impact on the provision of services and the welfare of Baby F?

3.9 Was practice consistent with organisational and London Safeguarding Children Board procedures, BSCB Protocols and Policies and wider professional standards including the LADO and child death review process.

4. Context of report / Sequence of events.

4.1 For the purpose of reflection and clarity the sequence of events, analysis and learning have been identified into episodes of care with a final summary of overarching themes for learning.

The Antenatal period; 10.10.2011 to 1.1.2012.

4.2 Mr and Mrs F were previously unknown to health services in the area until Mrs F registered at her new GP surgery, she was then seen seven times by health services until the birth of Baby F for routine or booking contacts.

4.3 *10.10.2011*: when Mrs F registered with her GP for a new patient check, she was seen by a health care assistant (HCA) who took a brief medical history which showed no particular issues, noting minor illness and immunisations only.

4.4 Mrs F advised that she is 28 weeks pregnant and follows a vegan diet, the HCA referred her for a GP consultation and Mrs F was seen that day by a locum GP who subsequently referred her into secondary/midwifery care. Mrs F was not seen again within primary care during her antenatal period.

4.5 *1.11.2011*; Mrs F was seen for the first time by the community midwife following a self-referral to the service at 30 weeks pregnant. At this contact the baby was recorded as small for dates, routine screening tests (NHS Antenatal Screening Programme) were offered but declined and no advice was given re Vitamin D supplements.

4.6 The next contact was on 1.12.2011; where formal routine booking was completed, Mrs F was by now 34 weeks pregnant. A risk assessment was undertaken taking into account Mrs F's medical, social, obstetric history including the late booking, the declining of routine screening, noting family history of diabetes and small for dates presentation. A referral was made to the consultant obstetrician.

4.7 2.12.2011; The GP practice received notification via the electronic booking form which advised that Mrs F was 34 weeks pregnant, a vegan, has had rubella vaccination and has consented to some tests but refused others on 'religious' grounds.

4.8 Following the referral by the midwife Mrs F was seen on the 7.12.2011; by the Consultant Obstetrician, during which time she expressed her unwillingness to seek care for either herself or her new born baby in the event of illness. This additional information prompted the obstetrician to request a referral to children's social care, this was however not completed.

4.9 20.12.2011; at a routine appointment with the community midwife, tests for diabetes screening and an ultrasound were declined and the baby was noted as still being small for dates.

4.10 28.12.2011; A week later Mrs F was noted as having painful and irregular contractions, but declined a labour assessment. The Ambulance service was called to the home address on 30.12 and transferred Mrs. K to hospital in established labour.

Post natal period in hospital.1.1.12 until 6.1.12

4.11 Baby F was born in hospital at 01.07 hours on the 1st of January 2012 with a routine labour and appeared well although he was a low birth weight and noted to have intrauterine growth retardation (IUGR).

4.12 A detailed discussion was had regarding the value of maternal screening and Mrs F gave consent for maternal blood screening.

4.13 Soon after birth the paediatrician discussed the value of administering vitamin K but the parents declined this treatment. Mrs F informed the paediatric registrar that her religious beliefs did not allow her baby to have tests and stated she did not want her baby to have any tests. She also stated that the family were strict vegans and wanted to exclusively breastfeed but would accept soya milk top ups.

4.14 Discussions continued with the parents throughout this first day and then over the following two days in relation to the test required and the importance of the administration of Vitamin K.

4.15 During the first 12 hours of life Baby F developed concerns in relation to his blood sugar level and following review he was moved into the SCBU.

4.16 Over the following two days concerns continued to grow around the Baby F's health and on 3.1.11; An initial meeting and discussion was had with his parents to explain the complications of his low birth weight. This included the need for phototherapy, adequate hydration, regular food and antibiotics. Over the course of a number of discussions the parents agreed incrementally to intravenous fluids and phototherapy but not the Vitamin K treatment.

4.17 The paediatrician expressed to the family that social care would need to be involved if their child's care was compromised.

4.18 During the course of the day Baby F's condition continued to deteriorate despite active treatment and his worsening jaundice, respiratory distress and suspected infection led the paediatric team to have a further debate with the parents, strongly advising on treatment. During the day this concern led to the involvement of the safeguarding nurse and further communications with the parents advising them on the urgency of the treatment, however despite the collaborative approach the parents continued to refuse to consent to the treatment required (Vitamin K administration).

4.19 This lack of consent led to a social care referral being completed and faxed to children's social care after a telephone discussion by the safeguarding nurse late that afternoon.

4.20 Mr F consented to administration of the Vitamin K to Baby F a few hours later that evening.

4.21 The following day, 4.1.2011, further conversations continued with the parents and Mrs F advised the safeguarding nurse that her sister works as a midwife and her husband, Mr F was an adult respiratory nurse. She expressed that her religious beliefs were a contributory factor to not having antenatal care but Mr F noted that the refusal for the Vitamin K treatment was due to his belief that it was purely for government statistics.

4.22 The parents both stated that they would not object to further treatment and would bring the baby back to hospital if he became unwell.

4.23 The safeguarding nurse advised children's social care that the parents were now accepting treatment and requested that a senior manager consider a strategy meeting prior to discharge of the baby. Later references suggest that the safeguarding nurse indicated that this was no longer necessary.

4.24 Following the referral children's social care (CSC) sought legal advice in relation to this scenario, this was prior to being informed that the parents had given consent.

4.25 5.1.2011; Children's social care held a strategy discussion in response to the concerns raised, which included the police, the social worker and it appears that the safeguarding nurse provided information via the referral. The result of this discussion was that a single agency (social care led) enquiry was required under section 47 of the Children Act 1989.

4.26 Baby F's condition improved considerably over the next three days, he was back to his birth weight and he was subsequently discharged from hospital on 7.1.2012.

4.27 No discharge planning meeting took place.

4.28 An agreement was made for a joint post discharge visit between the health visitor and the social worker, a discharge summary noting all the events was sent to the GP and a follow up hospital appointment was made for 6-8 weeks later.

4.29 The health visitor was informed by the paediatric liaison health visitor at the hospital of Baby F's imminent discharge and brief details of his birth history, his family and the sequence of events.

Post discharge until Baby F's death, 7.1.2012 to 14.06.2012

4.30 The community midwife telephoned (rather than visited) on the first day post discharge at the family's request and then visited Baby F twice at home until 13.1.2012 when they discharged him from their care.

4.31 12.1.2012; The health visitor and the social worker undertook a joint visit to the family home. The health visitor undertook a new birth visit and the social worker undertook the core assessment.

4.32 There were no concerns regarding Baby F noted on the visit, the house was warm, interactions with his parents were good and he was feeding well. The father's employment as an adult nurse was noted as was the support the parents were receiving from other family members who were medically trained and also their church.

4.33 The parents discussed the refusal of the Vitamin K stating that it was due to lack of information rather than based on their religious beliefs and that the hospital had not been clear about their level of concern.

4.34 Mrs F spoke about her faith in God stating ' he would make everything well'. She noted that she had had blood tests herself due to pressures from the hospital staff. The parents both cited professionals as being rude and judgemental of their beliefs but stated that their spiritual beliefs made them refrain from formally complaining. They reiterated that they were both vegans and that they did not take supplements due to their beliefs. They advised that they had yet to decide if they would have their baby vaccinated.

4.35 The social worker concluded that the parents were working well with health and were meeting their child's needs and made a decision to close the case.

4.36 This decision was supported by the social worker's manager who signed off the assessment noting that there may have been 'crossed wires' at the time of the baby's birth and that there were no ongoing concerns evident.

4.37 Baby F was seen once more at home by his health visitor, 20.1.2012 where he had gained weight and Mrs F appeared relaxed. A discussion was had re giving Baby F his immunisations and it was noted that the parents had not yet made a decision. A reminder was given to book his eight week check and confirmed that Mrs F's six week check was booked. No concerns were raised.

4.38 The next time Baby F was seen was in clinic by another Health Visitor, 9.1.2012; although he had gained weight he had dropped below the 0.4 centile. No follow up action was taken.

4.39 15.2.2012; Mrs F attended her six week post natal check, it was recorded that she continued to breast feed, no comment was made re giving dietary/vitamin supplements.

4.40 17.2.2012; Baby F missed his hospital follow up appointment.

4.41 29.2.2012; Baby F attended the Health Visitor clinic where he was found to have had a reasonable weight gain. The health visitor noted that he was still being breast-fed and discussed supplements with the parents. They also discussed the immunisations, the parents stated that they did not want either of these. They did agree to attend the eight week developmental check the following week however they subsequently did not attend for this appointment.

4.42 This was the last time that any professionals saw Baby F alive.

4.43 He also did not attend his second follow up appointment at the hospital on the 15.5.2012, following this the hospital wrote to the GP asking for Baby F to be reviewed and particularly with regard to his weight. The letter states that no further follow-ups would be sent but that the paediatrician would happily review the baby if the GP had concerns.

4.44 14.6.2012; Mr F called the police to the family home saying that their 'son had no sign of life'. The police report that he had been in cardiac arrest for 10 minutes prior to their arrival and that CPR had not been attempted by the family. The parents later reported that Baby F had had a cough since April and been unwell for about three days; he had not been feeding properly and had swelling around his eyes and arms.

4.45 An ambulance was called and Baby F was transferred to hospital where despite attempts to resuscitate him he was pronounced dead at 19. 12pm.

Post Baby F's death.

4.46 Children's social care duty team were informed of Baby F's death by the police on 14.06.2012 and the health visitor and GP were informed the following day by the hospital. On the same day the health visitor became aware that Baby F had not attended either of his hospital follow up appointments, the reasons for this delay were not apparent.

4.47 25.6.2012; A Multi agency rapid response meeting took place attended by the designated paediatrician, the police, children's social care and representation of the health visitor via the named nurse. The meeting considered the events of Baby F's birth and issues regarding lack of consent, the referral to children's social care, the history of his ill health from April, including the deterioration in the final few days and the lack of seeking any medical attention. The outcome was for there to be feedback to the CDOP although this is not reflected in the minutes.

4.48 The health visitor visited the family to offer support and condolences. The parents described that Mr F had tried to resuscitate Baby F but his skills were not good and he was too distressed.

4.49 They stated that they had not taken Baby F to his developmental check as it had seemed like a waste of time and would expose him to germs. Mrs F stated that they had not taken him to the hospital appointments as he was gaining weight and being seen by the health visitor so they saw no need. They also stopped attending the clinics as he was doing well and she didn't want him to get upset or exposed to germs. Mrs F stated that she had learned from her mistakes regarding the vitamin D deficiency and that in future she would ensure that her levels were not low and therefore not putting a baby at risk. She noted that they were probably low at that time.

4.50 On the 13.8.2012 Mrs F was started on iron and vitamin D following a blood test, it was unclear who had initiated this request. Mrs F was seen on 12.12 2012 and she reported that she was pregnant. The GP contacted the designated nurse for advice re contacting social care and they decided to await the scan results before making a referral.

4.51 18.12.12: Mrs F's GP was informed that she has had a miscarriage.

4.52 5.9.2012: The CDOP met and considered the findings of the post mortem, information from the agencies involved and the Rapid Response meeting.

4.53 The outcomes of the CDOP were to refer to the Local Authority Designated Officer (LADO) to refer Baby F's father for investigation regarding his role and his possible neglect of Baby F's medical needs and to request the LSCB chair for consideration of the case by the SCR panel. The police also contacted the Nursing and Midwifery council in reference to the conduct of the father and his capability/suitability as a registered nurse.

5. Analysis of Involvement.

5.1 Over the period of the events surrounding Baby F's short life there are a number of common themes in relation to agencies' practice, these include some evidence of good practice and compliance with procedures. There are also however a number of occasions where practice feel short of expectations and opportunities were missed and the following narrative cites those specific examples.

5.2 Across all the agencies there are examples of;

- A lack of ownership and accountability in practice
- Newly qualified and/or inexperienced practitioners with poor senior management oversight of the case,
- Poor quality of assessments, influenced by a lack of depth and rigour of analysis and interpretation of information that ensures effective analysis of risk,

- Poor ongoing assessment of risk with little evidence of considering the totality of events and behaviours.
- Poor compliance and in some cases lack of knowledge of policies and procedures.
- Poor inter and intra agency communication, including inconsistent and at times lack of documentation.
- Little challenge of parental views and in particular a passive acceptance of the parents description of the constraints on their health behaviours prescribed by their faith.
- Limited evidence of the voice of the child in professional decision making.
- A sense of relief once the parents had consented to treatment that minimised the level of existing risk for the child.
- An apparent lack of evidence of awareness/knowledge of the impact of maternal nutritional status on the health of either the unborn or new born infant.
- An apparent lack of understanding/knowledge of the role of the LADO and reporting requirements across agencies.

5.3 These examples were common themes that resulted in a lack of recognition of concern/risk and subsequent lack of response.

Antenatal period.

5.4 Mrs F's first contact with her GP was when she registered at a new patient check where it was identified that she was 28 weeks pregnant. It may have been reasonable to assume that she had only recently moved into the area however further investigation could have provided an insight into why she was booking so late in her pregnancy which would be seen as unusual especially for a first baby.

5.5 The actions of the HCA in referring her immediately for GP consultation was good practice as was her recording of the late booking and her adherence to a vegan diet.

5.6 However the reasons for this were not then explored by the GP and the fact that she was a high risk pregnancy was not identified or acknowledged in the practice. Whilst the GP made a referral to the hospital for antenatal care there is no available documentation to that effect and therefore any concerns and possible implications are unlikely to have been understood by health professionals subsequently involved in Mrs F's care.

5.7 The GP practice failed to address Mrs F's vegan diet and its impact on either her or her child's health. Women who follow a vegan diet in pregnancy are at risk of deficiency in iron and vitamin B12, pregnant and breastfeeding women are also at risk of inadequate Vitamin D uptake and as a black African Mrs F was further compromised by the risk of vitamin D deficiency. All these factors were known at the time of her first appointment and should have been discussed in detail with Mrs F by her GP. NICE guidance in 2008 noted the increasing prevalence of rickets and the need for vitamin D supplements in certain cases and recommends routine assessment within antenatal care for vitamin D supplements. The government issued guidance in relation to Vitamin D supplements in pregnancy in 2012 and it can only be assumed that this practice were unaware of this guidance. However this is a

common feature in this SCR as no other health practitioners appeared to proactively follow this guidance/recommendations.

5.8 This was also a missed opportunity to share information that should have informed both the midwife and her health visitor of the level of risk for Mrs F and her baby.

5.9 Mrs F self-referred to midwifery care at 30 weeks, this late booking plus an unborn infant showing small for dates and declining of routine tests including the ultra sound scan should have prompted an assessment and identification of a high risk pregnancy at this point. Delayed bookings are also supposed to be followed up within two weeks of first contact in accordance with the hospitals' procedures however formal booking was delayed by almost four weeks and no intervening actions were taken. This has been identified as a failing on the part of the appointment system however it is unclear why the midwife or manager did not identify this delay and advise a home booking or alternative venue. It may suggest that the level of risk was not recognised as significant.

5.10 At the formal booking a risk assessment was undertaken and a referral was made to the consultant obstetrician which is good practice, although a detailed discussion with Mrs F re her diet, the baby's weight and the family's declining of tests was not explored until she was seen a week later by the consultant.

5.11 At this appointment further concerns were noted and the consultant was the first professional to recognise that the expressed views of Mrs F posed risks for Baby F. He appropriately requested a referral to social care which is an example of good practice however this key action amounted to nothing as the referral was not actioned and the consultant did not follow up to ensure that the referral had been made. The midwifery and obstetric professionals work within a team approach and the clinics are very pressured for time. This results in the medical staff delegating their safeguarding responsibilities to the nursing staff, and whilst this may be acceptable in terms of practicalities in some instances, the process can also lead to professionals delegating their accountabilities, which is poor safeguarding practice.

5.12 To compound this the junior member of staff appeared not to have fully understood the request for a social services referral and instead completed a concern and vulnerability form. Within the hospital this form has been amalgamated with the CAF for ease of completion and to avoid duplication, in this instance it is unclear why this form was used and what happened to the form itself as it was not highlighted in subsequent interactions with the family or triggered the expected case presentation for high risk cases. This may have been a result of confusion in relation to the current hospital processes that had recently changed and a lack of knowledge of processes for flagging concerns to senior staff. Senior midwifery overview of practice appears to have been absent and if present is likely to have identified the confusion and flagged the need to escalate concerns.

5.13 It is unusual for mothers to decline screening test in pregnancy especially ultra sound scans as these are usually an eagerly anticipated event. Pregnant women do have the right to

decline treatments and screening during pregnancy and it is good practice to recognise individual choice and cultural diversity. This also applies to the decisions made in relation to diet however in this instance it would appear that the voice and rights of the parents outweighed the obvious risk that these choices could have on the child. The midwives respected the parents expressed religious beliefs which is good practice however there was no professional challenge in relation to the extreme nature of the facts that were presented by the parents of this particular belief system.

5.14 In addition to this the professionals should have been well aware of the NICE guidance (2008) relating to vitamin D supplements in pregnancy in particular for black African mothers, plus the fact that Mrs F was a vegan should have increased concerns for the baby's' wellbeing particularly in light of parental non compliance with proactive screening.

5.15 Despite the concerns noted at this appointment and continued presence of the same risk factors the concerns were not raised again during the antenatal period and no one questioned the lack of escalation of the consultants concerns. One could assume that as Mrs F had been seen by a number of professionals during this time, staff assumed that the risks were either being managed or that they did not indicate a significant concern, also as noted the rights of the mother were seen as prominent. There is no evidence of professional curiosity or challenge of practice in the face of a number of high risk factors

Post natal period.

5.16 Mrs F's labour and birth of Baby F were appropriately managed and the involvement of the paediatrician at the birth was indicative of good practice recognising the possibility of complications in light of the lack of maternal history. This good practice continues over the following days as the paediatrician maintained consistent and active involvement with the baby and his parents as his condition deteriorated. There are good examples of working closely with the family recognising their religious beliefs and culture and providing guidance and information in relation to the required treatment. The team also articulated early in the process that the well being of the child would take precedence and this included the early involvement of the safeguarding nurse.

5.17 An appropriate referral was made to children's social care when the health staff felt that the Baby F was vulnerable and needed protection due to his parents' lack of consent to treatment. This included an initial telephone consultation by the safeguarding nurse and a timely faxed referral.

5.18 It would appear however that there was no challenge of the parents representation of the religious sanctions despite these being quite extreme and likely to put Baby F at risk. This may have related to an assumption that the safeguarding nurse had experience in the culture and belief systems and therefore these were genuine practices. It also suggests that the focus of attention was on consideration of parental choice. The parental issues appear to have clouded the professionals' ability to focus on the experience of the child.

5.19 There was also no exploration of the contradiction of the parents accessing preventative treatment for themselves yet denying the same for the child. The father's professional role as an adult nurse was known at this point but it neither informed the risk assessment nor initiated a referral to the LADO. It would appear that staff did not recognise the implications of his role either on his own child, his behaviours or potentially on other vulnerable patients in his care.

5.20 If these issues had been explored they may well have led to increased concerns in relation to the personal behaviours of the parents which may have meant that the concerns did not dissipate once the parents had given consent but portrayed a different picture of risk in the longer term. However it would appear when on reflecting on the marked shift from acute preventative action to minimal concern that the concerns were one dimensional, focussing by this point solely on the lack of consent.

5.21 The children's social care team appropriately sought legal advice and responded to the referral in a timely manner. The strategy discussion was not undertaken within a face to face meeting, this is in itself not poor practice however given the level of concern and initial response by CSC it is unusual. Presumably this was because by this time the concerns had dissipated as the parents had given consent. The referral form also appears to have been focussed on the parental refusal for treatment once the baby deteriorated with minimal information provided on the antenatal history particularly the declining of key screening and uptake of supplements. It is unclear if this relates to the transference of detail from the original telephone consultation or from the faxed form.

5.22 A key concern is the omission of the paediatrician in the strategy discussion as it is likely that this would have both occurred face to face at the hospital and provided a comprehensive picture of the risks. It is assumed that the safeguarding nurse's contribution to the discussion was via the referral however there appears to have been confusion as to the role of this nurse with social care believing that this was a named nurse and thereby assuming a higher level of safeguarding expertise. It could also be suggested that the safeguarding nurse also felt that once the parents had complied with the treatment the risk had gone, this is reflected in the discharge summary to the GP.

5.23 The strategy discussion form is brief on detail and lacks analysis on the rationale for progressing to a Section 47 enquiry, this undermines effective risk assessment. In particular the information on the form should inform the investigating social worker of the background and actions required and subsequent assessments may well be compromised. In this case this lack of rigour and detail could have suggested that the concerns had been eradicated and may explain in part why the seriousness of the situation was minimised going forward.

5.24 This lack of ongoing concern may also be the reason why there was no discharge planning meeting although this is a requirement under the Policies and Procedures (see Kent and Medway safeguarding children procedures 2010 section 5.25) whenever a professional or agency has raised child protection concerns about a child admitted to hospital.

5.25 The final strategy meeting and discharge planning meeting could have been combined however the lack of the discharge planning is a key missed opportunity. It is at this meeting that the comprehensive picture of events could have been identified, professional questioning and a robust risk assessment should have arisen through the multi agency discussions and reporting. The lack of this meeting further illustrated a picture of minimal concern by professionals and potentially provided both the parents and other professionals with no sense of concern for their behaviours as there was no clear plan to monitor them and Baby F once home.

Post discharge.

5.26 The midwifery service continued to support the family appropriately until the health visitor had taken on the care of the family and this is good practice although there is no evidence of earlier communication between the two services which would have been expected in a high risk family. This is presumably due to the lateness of the booking although this should have increased the need for communication between the two services.

5.27 The HV undertook the new birth visit with the social worker which as good practice afforded them both the opportunity to explore in depth the parental behaviours. However the visit was extraordinarily optimistic and the parents were seen to be very co-operative. The nature of a new birth visit may have distracted from the need to explore, challenge and analyse the situation and the information available from the history. The decision by the social worker to close the case appears to have been made on the basis of an assessment that contained little depth and rigour. As previously stated this may have been influenced by the considerably reduced concerns noted at discharge, the lack of a discharge meeting and the parents compliance at the home visit.

5.28 There was a lack of any agency checks, which if undertaken is likely to have provided a more complete picture of the risks.

5.29 The detail within the core assessment is suggested to be more in line with an initial assessment, lacking analysis and identification of risk. The assessment was also completed within a very short time frame and notably less than the requirement, this reflects the lack of concern felt by the social worker.

5.30 The social worker appears to have been reassured that the parents were engaging with health services and presumably felt therefore that if there were any concerns the health visitor would seek further advice from CSC. It was appropriate that health became the lead agency however this assessment of compliance was based on minimal evidence. Also whilst the management of the baby's weight was a health responsibility there appears to have been no challenge from the social worker in relation to recognising the impact of this on the baby's vulnerability or the lack of a plan to monitor appropriate weight gain.

5.31 Both the social worker and the HV accepted the parents' assertions that they had not withheld treatment and although subsequent enquiries with the hospital advised that this

was not the case there was no challenge by either professional. The details of the protracted discussions with the parents were available on the referral form however this did not factor on the assessment. There was no consideration of the contradictions between care accepted for themselves and that provided to their child. The parents repeated their religious beliefs and approach to screening and supplements and it was noted that Mrs F had low haemoglobin and was a vegan who was breast feeding. None of this information appears to have informed the assessment by either professional.

5.32 The parents stated at the visit that they felt that the staff at the hospital had been rude and pressurised them, it may be that the HV and social worker felt that they did not want to be seen in the same light and potentially subject to a complaint or to be judgmental.

5.33 Baby F remained underweight at the visit however evidence of weight gain appeared to reassure both the social worker and HV. The vulnerability of the baby due to his IUGR was not identified indeed the interaction and co-operation of the parents appears to have held great weight in the assessment despite this being on limited experience and the parents ability to remain engage was untested.

5.34 The social worker involved in the case was newly qualified although known to the team, this may explain her optimism however the supervising manager should have provided guidance around the level of assessment required and provided a greater degree of challenge to the assumptions made.

5.35 The health visitor made an appropriate decision to identify the family as one in need of 'targeted' intervention however the rationale for this decision and then the subsequent decision to reduce the level of need is not evident, nor are the corresponding levels of activities associated with these decisions.

5.36 It would appear that the HV was not provided with the Neonatal discharge summary, which would have informed her assessment of risk, however she had had a hand over by the liaison health visitor at discharge.

5.37 There is no evidence that the GP recognised the level of risk noted in the discharge summary or sought any advice or assurance from either the HV or the midwife following their interactions with Baby F on his wellbeing. It is unclear how effective the communication between the GP, HV and midwives are within the practice.

5.38 This lack of identification of risk and inter-professional communication was also highlighted when the GP was informed by the hospital of the missed out patient appointments. The paediatrician specifically requested that the GP reviewed the child, this should have raised an alert within the practice and a proactive response initiated. The GP advises that this was passed to the HV although no evidence for this is available, however even if the responsibility was delegated the accountability remains the GP responsibility and this should have been followed up. This was a significant missed opportunity and it is difficult to ascertain the reason for this lack of response by any of the health professionals. Failure to

attend clinic appointments is a clear potential for concern as noted by CEMACH 2008 noting it as a possible indicator of a family and child's vulnerability. GP practices were issued with a suggested process for ensuring the follow up of these families in 2009 following a local SCR, (this has also been reviewed and reissued in January 2013). In this case the process was clearly not followed.

5.39 This may be another indication of the lack of risk assessment and awareness by professionals in this case. In this instance the consultant letter also advised that there was no intention to follow up the baby at the hospital so the GP may have perceived this as a low level concern. This may explain why he did not follow up the lack of feedback from the HV possibly making the assumption that she would have contacted him if she had any concerns.

5.40 The hospital also failed to recognise the significance of the missed appointments particularly in light of the previous history of non-compliance, this should have promoted direct communication with the GP, HV and children's social care given their previous involvement. Discussion with the named nurse is likely to have escalated this and initiated the appropriate communications. It is likely that given the previous involvement if CSC were notified of the missed appointments this would have triggered a review.

5.41 The actions undertaken would suggest that the consultant believed that he had delegated his responsibility when asking the GP to follow up Baby F, as noted previously accountability however must not be delegated. This also appears to repeat the theme relating to the lack of assessment and comprehension of the level of risk for Baby F. This case reflects the concerns noted in a previous SCR in 2009 in relation to the importance of a full consultant review and the previous recommendations appear not to have been followed in this case. It is unclear from the evidence how well informed with these recommendations the medical staff are within the hospital, but this SCR would suggest that they are not embedded into practice.

5.42 The HV would appear to have been reassured by the attendance of Mrs F and her baby at the clinic, the weight gain noted at the second home visit and the clinic visit on the 29.2.2012 however the previous clinic visit had shown poor weight gain with Baby F being below the 0.4 centile. This concern does not appear to have been identified, if it had been then the HV may have considered checking on the baby when he did not attend further clinics rather than relying on the most recent weight. The post mortem found Baby F to be considerably underweight at the time of his death and the sequence of events would show that there was a gap in overview of his weight. It is not clear if there was a threshold of desired weight gain and close monitoring of progress which seems to be an oversight given Baby F's birth history of IUGR and subsequent low positioning on the centile chart. This lack of a plan would suggest that the vulnerability of Baby F in relation to adequate nutritional intake was not recognised and in particular little regard appears to have been given to the impact of Mrs F's nutritional intake on Baby F.

5.43 The mother's six week check also provided an opportunity for the GP to review the mother's dietary intake. The GP should have been aware of the importance of breastfeeding mothers to take vitamin D supplements and this would have been even more relevant in Mrs F's case

due to her ethnicity. The GP would have had access to the antenatal and birth history and this would have enabled him to make a more thorough assessment of both the mother and babies needs and it would have been appropriate for him to have advised or prescribed vitamin drops for the baby. This is good practice even in the absence of the concerns that surrounded Baby F.

5.44 Another lost opportunity was the lack of follow up of the family when they missed the 8 week check, given that the family had informed the HV that they did not intend to give the baby his immunisations a follow up appointment at home would have been appropriate in this instance. It is unclear why this lack of engagement did not escalate concerns from the HV or GP it can only be assumed that the previous reassurance that the HV had received meant that she did not recognise the level of risk and presumably the GP was unaware.

5.45 This missed appointment alongside the missed hospital appointments should have triggered significant concerns on their own but particularly in light of the antenatal and postnatal history a further urgent discussion with CSC was required. The basis of co-operation and engagement upon which the core assessment was founded was no longer present but it does not appear that these collective factors were recognised therefore no further action or escalation was taken. This lack of concern continued when the family did not attend any further clinic appointments, given the vulnerability of the baby it would seem appropriate that this family had a low threshold for proactive contact. The HV does not appear to have reassessed the baby's needs or vulnerability at any time in the process in particular when contact dropped off. Baby F had not been seen by any professionals for three and a half months by the time of his death. This is not unusual for well babies although one would expect to see mothers and babies fairly regularly in the first six months of life. In Baby F's case the assessment had been closed on the basis that the HV would continue to have contact and engagement, there is no evidence to suggest that the level of vulnerability for this baby had reduced. It is unlikely that this case was discussed at the HV safeguarding supervision, as he was not on a child protection plan. It would appear that there is a lack of robust oversight in the management of cases such as this. Discussion with the safeguarding nurse during supervision would have raised the awareness of the growing vulnerability of this baby.

5.46 Baby F's father was working as an adult respiratory nurse at this time, this was known to agencies over the period of their involvement however no agency referred to the LADO. There were three separate occasions when concerns should have been raised this included the rapid response meeting. However it was not recognised as a safeguarding issue until the CDOP in September 2012, at this point a referral was made. It is unclear why there was a break down in multi agency working in this respect, evidence suggests that whilst agencies reference that they recognise and understand the role of the LADO there is little evidence of engagement.

5.47 The LADO made an appropriate request for a strategy meeting in September 2012 following the local policy, however this never took place. It is unclear why this was the case, however.

There appeared to be little oversight by the LADO of this case and it may simply have been missed.

5.48 At the time the LADO role was described as busy and difficult to manage competing demands, The LADO role and process is currently being reviewed by CSC as part of the Improvement Plan.

5.49 A rapid response meeting was held in a timely manner however it does not appear to have recognised the potential for neglect in this case; this appears to reflect the theme throughout the case of a lack of analysis and understanding of the presenting factors. The impact of the parents cultural and religious views hampered the assessments and decision making during Baby F's life and these would appear to have also impacted on the findings of the meeting. Given that the rapid response meeting has the power of hindsight and a full picture of all the information it is of concern that the assessment and decisions continued to be weak. There may have been more of a focus on the parental behaviours and determining the rationale behind them rather than considering if neglect contributed to Baby F's death. There also appears to have been little challenge within the meeting of the decision to defer the case to the CDOP. This may have been due to the professionals awaiting the results of the post mortem and police investigation before committing an opinion.

5.50 There is evidence of good practice at the hospital, Acute Trust 2,following Baby F's death as there was recognition of what life must have been like for him leading up to his death.

6. Learning from the case.

6.1 There are a number of common themes running through the case and these and the specific points have formed the basis of the recommendations made by this review. The specific points have been noted within the chronological order in which they occurred.

Specific points

Ante-natal period

6.2 When Mrs F registered with her GP practice it was evident that she had not received any antenatal care and was at an advanced stage in her pregnancy, she also refused some screening tests and noted her diet/nutritional intake. These factors should have alerted the GP to the vulnerability of both her and her unborn child. If the significance of these were not clear there was clearly enough cause for direct discussion with other professionals such as the midwife or health visitor. Effective communication would have raised the level of awareness at an early stage and if it had not indicated the need for a risk assessment at this point it would have contributed valuable intelligence that built a picture of risk over the coming weeks.

6.3 GPs note that changes to maternity care have resulted in little engagement with the midwifery service or with pregnant mothers and it may be that this distance contributed to the lack of recognition of the vulnerability of the unborn child. However these changes to the pathway do not detract from the accountability of all professionals who come into contact with vulnerable families and systems need to be in place to address any communication or knowledge gaps that this process creates.

6.4 Antenatal visits by Health Visitors to vulnerable families, such as Mrs F assist in effective communication and ongoing postnatal care. This visit would have informed subsequent antenatal and postnatal care and maintained a level of continuity of information that was lacking in this case.

6.5 Throughout the antenatal period there was a lack of recognition of the potential impact of the mother's diet on Baby F despite recognising that he was small for dates. It is important that professionals recognise the implications of maternal health on their unborn infants including the mother's diet. Recognition of this could have alerted the professionals to the need for close observation of Baby F's development at an early stage and informed subsequent risk assessment.

6.6 Late bookings are recognised as an indicator of risk and in this instance were another contributory factor to the baby's vulnerability. Whilst this was recognised in the booking as a risk factor it did not precipitate any action and there was then a delay in follow up. Senior oversight of processes could have identified both the delay and the risk and ensured that this was addressed quickly.

6.7 Despite the appropriate action by the Obstetrician requesting a social care referral in light of the presenting risks the systems and processes in place appeared to be have been muddled and roles and responsibilities do not appear to have been clear or fully understood. Senior oversight of the processes should have noted the confusion and lack of follow up of the expressed concerns. This includes the consultant who should have followed up on his request to determine the outcome.

6.8 Junior staff do not appear to have understood the differences between a social care referral, the concern and vulnerability form and a CAF. Support to this staff group could have both identified the mistake and supported the staff member to understand the level of concern related to each of these interventions. Clarity and appropriate referral at this stage would have resulted in a risk assessment and whilst direct action may not have been taken Baby F's vulnerability would have been recognised and this would have contributed to subsequent assessments, especially when the parents later refused treatment.

6.9 This was a key point at which the lack of professional curiosity impacted on Baby F's outcome. The nature of the spiritual beliefs and sanctions articulated by his mother were extreme and should have raised both concern and questioning. Simple exploration of these beliefs would have illustrated that these were personal views/behaviours as opposed to those of the church and would have informed the level of risk for the baby. Use of services

such as the hospital chaplaincy would have been appropriate and sensitive. However even if the faith organisation had supported the mother's statements this behaviour would still have caused concern for the baby's well being and should have been addressed. It is likely that anxiety relating to ensuring that the mother's needs are recognised and that the diversity of the parents was not compromised hindered a proactive approach. Professional efforts not to be judgemental are recognised as influencing the ability to apply safeguarding thresholds (Brandon et al 2005). This directly impacts on the recognition of the risk of significant harm for the child.

6.10 Litigation and or complaints against staff in relation to recognising the legal rights of the mother and the ethnic, cultural, religious rights of parents are likely to be influencing professionals' behaviour and in turn losing the voice of the child. The need to stay Baby Focussed is paramount and reflected in many safeguarding reviews including the Munro Review (2011).

Post natal period

6.11 During the immediate post natal period there continued to be a number of opportunities for staff to investigate and challenge the parents' representation of their faith's beliefs. This investigation would have alerted professionals to the risk that the baby faced from parents who failed to make their child's needs and wellbeing their priority. Whilst there was an appropriate escalation of concern the focus remained on consent for treatment and a deeper understanding of the parents' motives and behaviours was not sought out. This lack of adequate assessment and challenge would suggest therefore that when consent was finally given the concerns abated as no underlying concerns had been recognised.

6.12 The de-escalation of concerns post consent and subsequent actions reflect the lack of robust assessment and analysis.

6.13 Senior management and/or safeguarding oversight into the events could have brought insight and challenge to the events. This particularly relates to the 'named nurse' role. The expertise, influence and specialist knowledge of a named nurse whose responsibilities are defined within Working Together would have provided this function.

6.14 To compound this gap CSC believed that the interactions were with a 'named nurse' which is likely to have led in part to their lack of urgency assuming that the risk had been assessed effectively.

6.15 It is also apparent that the responsibility for this case was passed to the safeguarding nurse with the assumption that this post had the expertise and knowledge to effectively oversee the process.

6.16 The importance of the senior expertise and oversight of a named nurse cannot be underestimated in terms of understanding risk, interpreting behaviours and providing

challenge. There needs to be recognition of this role and adequate capacity provided to fulfil its responsibilities and to provide assurance at both individual and organisational level.

6.17 Throughout the case there are good examples of practice and compliance with policy and procedures however there are a number of occasions where these were not complied with. It is important to ensure that agencies and staff within them recognise the importance and value of procedures and policies in safeguarding children and embed them into practice with confidence. There is also a lack of senior oversight evident that should have provided internal quality and compliance assurance.

6.18 This is particularly pertinent in relation to the absence of a discharge planning meeting which was a significant missed opportunity and breach of the procedures. Whilst it is the responsibility of health to initiate, CSC should have challenged the hospital and ensured that this was undertaken. The co-operation by the parents at this point is likely to have deflected the level of risk however the procedures provide a framework that ensures a proactive multi agency approach to recognising and managing risk that are effective in cases where risk is both obvious and hidden.

6.19 Whilst a strategy discussion did take place it was not face to face and only included the Police and CSC with information provided by the safeguarding nurse. Given the level of concern previously expressed and the seriousness of actions this should have precipitated a full strategy meeting in particular including the paediatrician. This would have provided more detail and an opportunity to challenge it is also likely to have agreed a discharge meeting or plan.

6.20 During the strategy discussion none of the agencies involved questioned the lack of a full strategy meeting and whilst this may be due to an apparent absence of concerns following the consent no professional queried if there were any remaining concerns. There was also no query as to the lack of the paediatrician in the discussions or query as to whether there may be further information required for the purpose of the discussion. It appears that the strategy discussion was taken on face value and no individual members saw any cause or role for them to raise any queries.

6.21 The multi agency role of strategy meetings and its purpose in facilitating a questioning and analytical environment upon which to make informed decisions is vital in ensuring that effective decisions and plans are made that adequately protect vulnerable children. All agencies need to recognise their broader safeguarding responsibilities within that context.

Post Discharge

6.22 The core assessment lacked depth and rigour that will have directly impacted on the ability to effectively identify risk and subsequently led to poor decision making. It is likely that this was influenced by the reducing level of concern both implicit and expressed within actions leading up to the joint visit. However if a robust process of enquiry and analysis, as required

in an effective core assessment had been followed unresolved issues, contradictions in behaviour, parenting concerns and the baby's vulnerability would have been explored.

6.23 The overly optimistic and seemingly empathetic approach taken towards the parents is likely to have dominated decision making if all the available information had been thoroughly reviewed. The process of assessment within child protection should be undertaken over a period of time that enables a full review and analysis of available intelligence and engages all agencies involved in the Childs care. Following the procedures would have allowed that investigation and analysis in Baby F's case and would have provided a different assessment of risk.

6.24 Joint visiting between agencies and in particular health and social care for newborn babies is good practice, informing effective assessment and decision making. However the combining of the new birth visit with the initial assessment is likely to have detracted from the need to determine the level of vulnerability of Baby F. The purpose and focus of these visits is clearly different and it would appear that the more supportive, relationship building nature of the new birth visit took precedent.

6.25 This visit and the subsequent interactions continued to evidence the lack of professional curiosity and challenge. Both the social worker and health visitor had information relating to Baby F's history however did not question the discrepancies between the professionals and the parents' accounts of events. There was also no challenge on the contradictory approach that the parents took towards their baby's health care and their own. Whilst this may have been related to a desire to maintain a good relationship and cooperation with the parents during the visit, this could have been followed up as part of the assessment.

6.26 It is unclear if the parent's ethnicity or professional background served to divert the social worker and Health Visitor from raising any questions or challenge either to the parents or each other. The parents articulated their unhappiness with the hospital staff referencing feeling harassed and considering complaining. This may have intimidated the professionals and the anxiety at being the subject of a complaint particularly by a health professional and/or in relation to equality and diversity may have clouded their judgement. Supporting staff to be able to challenge parents regardless of their professional status and without compromising their equality and diversity responsibilities will ensure that care between respecting individual rights is balanced with protecting vulnerable children and adults.

6.27 There appears to have been no system in place to ensure communication between the hospital safeguarding nurse and the HV or named nurse within the community in cases where child protection concerns have been raised which would have informed the assessment. The process relies on the hospital liaison health visitor having adequate information available to recognise the vulnerability of the baby.

6.28 Baby F was known to have IUGR, however this did not feature in either professionals' assessment and the risk that this history plus the mothers nutritional status created was not factored into his subsequent management. A weight management plan would have been

good practice and should be implemented in cases where a baby has growth concerns even when families are cooperative.

6.29 Monitoring of adequate weight gain is clearly a health responsibility, however a comprehensive core assessment incorporates the health and well being of children and this should have featured in the core care plan with assurance being sought by the social worker.

6.30 Whilst the Health visitor identified the family for targeted interventions it was unclear what this would entail and what triggers would be monitored to ensure the baby's well being. Clarity behind decision-making is essential to recognise the risk factors to be managed and to inform the management plan. Staff need to understand and appropriately use levels of intervention and the frameworks that are in place in order for them to be effective and meaningful. A clear identification of the management plan associated with the 'targeted' intervention would have provided a framework for managing risk and recognising Baby F's increasing vulnerability.

6.31 During this period communications between professionals does not appear to have been effective in particular between the hospital, the GP and the HV. Baby F's vulnerability appears to have neither been recognised or articulated in communications so when the hospital advised the GP of the DNA's the significance of this was missed by both parties and therefore not followed up. The process for communication with the HV was not robust and therefore the request to follow up Baby F failed to protect him. Whilst there was clearly a lack of recognition of the baby's vulnerability, effective communication processes would have contained vital information to professionals involved and provided another opportunity to recognise the risk.

6.32 The lack of professional accountability by key individuals is highlighted during this time and identifies the need for all professionals to follow up on their actions and concerns. This is particularly important when care is passed on or picked up by other services as it is at these points that essential information and intelligence is lost and the baby's vulnerability increases. This is evident in the follow up of the DNAs by the both the Paediatrician and GP, the follow up between the two HVs, the communication passed by the GP to the HV and the follow up of the missed 8 week check.

6.33 The lack of action when Baby F failed to attend either of his hospital appointments or the subsequent 8 week check is likely to be have been a result of the lack of recognition of risk. However there is clear guidance issued by CEMACH relating to the follow up of DNA's, this is a common feature in the Victoria Climbie report findings and was significantly a finding in a local SCR in 2009. This would suggest that staff are not complying with the available guidance and recommendations and this therefore creates a weakness in the system to adequately protect vulnerable children. Systems and processes need to be robust, regularly reviewed and quality assured to ensure that they are embedded in practice.

6.34 Within this period effective senior oversight would have challenged the actions in place and are likely to have ensured a heightened level of response. This is particularly pertinent in

relation to the management response to the social workers assessment and the lack of safeguarding supervision in relation to this case for the Health Visitor. In both cases the role of the manager/supervisor would have been to challenge and reflect on the case and associated interventions. This role is vital within a quality assurance process and provides an essential safety mechanism for vulnerable children. In this case there was little analysis and challenge of the social care assessment and the HV did not choose to bring this case to supervision. Processes and systems need to ensure that the framework for senior and/or specialist oversight is effective and that staff recognise its role and importance.

Post Death

6.35 A rapid response meeting was held in accordance with the Child Death Procedures however it would appear that this process also lacked rigour and analysis. The lack of senior representation and understanding of roles within the meeting will have contributed to the poor outcome. This level of expertise would also not have needed to have had the post mortem and police investigation results before committing an opinion. In some instances a strategy meeting is also called following an unexpected death of a child and this would have investigated the possibility of neglect however if a rapid response meeting is effective then it would fulfil this function.

6.36 The LSCB rapid Response template was not used and the documentation was poor. The minutes of the meeting were incomplete and of a poor standard, there was no reflection of any discussion in relation to neglect in this case.. This may have been due to the lack of debate in the meeting however this is not clear and therefore the information available in the notes would not have provided adequate information to inform any subsequent decision making.

Common learning themes

6.37 There are a number of common themes noted throughout the case review, these run like a golden thread through the agencies involvement with Baby F and his family. These apply specifically to CSC, acute trust 1, the GP practice and the community service (HV) due to their involvement in Baby F's care. However they cannot be seen to be exclusive to those agencies as the evidence is not available to demonstrate with confidence that all agencies would have managed these issues differently.

6.38 This was a preventable death and a number of opportunities to protect Baby F were missed. The nature and number of these themes would suggest that generally safeguarding practice was poor in this case. The recognised ' safety nets' within practice did not kick in so there was a cumulative picture of low risk that developed and this was not challenged.

- The quality of assessments was poor with little recognition or analysis of risk and therefore decision-making was flawed.

- Professional practice focussed on maternal /parental needs over the needs of the child. There was no evidence of challenge of the parents' views/representations or of their contradictory behaviours with a resulting loss of focus on the child.

- The ethnicity, diversity and possibly professional status of the family distracted professionals from challenging them. Supporting the equality and diversity rights of the family appeared to take precedence over the voice of the child.

- There was a lack of ownership and accountability by professionals, delegation to junior staff or other professionals was evident and there was no follow up or review of concerns. This contributed to the lack of identification of risk and increasing vulnerability was not picked up.

- There was a lack of senior management oversight, this includes directly to support junior staff and organisationally. Roles were often confused and not understood. The quality assurance function of management oversight was missing and led to continued poor assessment and decisions.

- The role and function of named nurse in acute trust 1 was not utilised as set out in Working Together and led to confusion for other agencies.

- Policies/procedures and guidance were not complied with in particular Discharge planning, DNA management, Core Assessment, rapid response meetings, managing allegations, the LADO role and nutritional guidance. This contributed to the lack of effective risk assessment and planning.

- There was poor Inter and Intra professional communication, leading to gaps in knowledge, misleading risk assessment and awareness of vulnerability.

- The lack of understanding of the impact of maternal nutrition/health on the unborn infant/baby resulted in no identification of risk or management plan.

- There was a consistent lack of professional curiosity and challenge to both parents and other professionals, this contributed to poor assessment, lack of recognition of risk/vulnerability and subsequently poor ineffective management.

- The role of Named senior officers within agencies and the LADO role and process was not used and does not appear to be understood.

- There are familiar learning points identified within this case to a previous local SCR in 2009 which suggest that previous learning has not been embedded into practice.

- The repeated lack of recognition of risk was not recognised as there was no professional who considered the whole picture or challenged previous decisions or lack of them. This

lack of identification of increasing vulnerability also appears to have conversely provided reassurance and served to reduce the risk observed by professionals as care unfolded.

7.0 Recommendations:

There are a number of recommendations made within this report some of which build on individual agencies recommendations.

As previously noted the main issues relate to learning within CSC and some Health agencies due to their involvement. Other agencies had little contact with this family either antenatal/ post natal or post discharge.

The recommendations in a number of cases relate specifically to the agencies who had the contact related to that learning point. However within the principles of safeguarding children all agencies should reflect on the lessons to be learnt and the recommendations and consider what measures or assurances they need to review within their own area of professional practice.

Whilst the Police and acute trust 2 had very little contact with this family and therefore a number of the specific recommendations do not apply to them they are advised to consider which of the recommendations would benefit their practice.

A key learning point that should be considered across all agencies is the need for considering the tension that arises from the sensitivities and requirements of meeting the equality and diversity agenda whilst actively safeguarding children. These two issues can be conflicting and staff need support and training to both recognise and mange this tension, ensuring the child is adequately protected.

Communication is addressed within agencies action plans relating to the specific instances where this failed Baby F, however poor communication is a common theme and is noted repeatedly in SCRs. All agencies and the BSCB should reflect on the need to continually promote good inter and intra agency communication.

The report suggests that there were a number of missed opportunities to protect Baby F and that practice was poor across a number of areas. BSCB will need to be assured that the systems and processes in place to provide it with assurance are effective.

At the time of this report CSC are under improvement measures and a number of the issues raised within this report are reflected in the improvement plan in particular the quality of assessments. BSCB will clearly be monitoring the improvement plan as part of their business.

A number of concerns have been noted across health agencies and the report advises that the CCG's assure themselves that the services they are commissioning are effective with regard to safeguarding.

1. BSCB (and Kent LSCB) need to review its assurance processes in relation to the section 11 audit.
   ***Outcome**: BSCB (and Kent LSCB) section 11 audit process robustly provides assurance of adequate safeguarding practice across member agencies.*

2. Health and CSC need to assure BSCB that staff are undertaking effective safeguarding assessments.
   ***Outcome**: Professional assessments are robust, holistic, informed and analytical and able to effectively identify the level of risk for the vulnerable child*.

3. Agencies need to demonstrate to BSCB that they have internal quality assurance processes including regular audit in place with regard to safeguarding.
   ***Outcome**: Safeguarding processes within organisations are effective and robust.*

4. BSCB will audit practice to ensure the embedding of the SCR learning into practice.
   ***Outcome**: The learning from this SCR has improved safeguarding practice.*

5. All agencies will ensure that staff are equipped and able to challenge and question other professionals and parents within their safeguarding practice.
   ***Outcome**: Staff will appropriately challenge and question parents and other professionals to protect vulnerable children.*

6. Health and CSC will ensure staff are equipped to balance the equality/diversity rights and/or professional position of parents with the needs of safeguarding children.
   ***Outcome**: Staff have the confidence and support to challenge and seek out advice in relation to the cultural/religious/professional status of parents in order to safeguard vulnerable children.*

7. Acute Trust 1 and Primary care need to assure the BSCB that the professionals within their organisations are aware of and undertaking their child protection accountabilities effectively.
   ***Outcome**: professionals recognise and fulfil their safeguarding responsibilities effectively.*

8. BSCB needs to audit that the appropriate Named Senior Officers roles are in place across agencies and utilised appropriately including consideration of the protection of vulnerable adults.
   ***Outcome:** Professionals utilise and inform the Designated Officers of cases where professionals working within statutory agencies are involved in child protection investigations*

9. Acute Trust 1, community services and CSC need to assure BSCB that management oversight and expertise of safeguarding is in place within their organisation and is monitored to ensure it is effective.
   ***Outcome**: Child protection concerns and safeguarding practice is quality assured by senior management oversight.*

10. Acute trust 1 to demonstrate that child protection competency frameworks/processes/levels are in place for staff.
    ***Outcome**: Staff are appropriately undertaking child protection interventions/actions in accordance with their level of skill and responsibility.*

11. The CCG's need to review the named nurse capacity and function within the Acute Trust (1) in line with the responsibilities as outlined within Working Together 2013.
    ***Outcome**: The named nurse role will be able to adequately fulfil the expectations and responsibilities outlined within Working Together 2013.*

12. The CCGs need to assure themselves of the efficacy of safeguarding arrangements within their providers in particular senior oversight of safeguarding practice.
    ***Outcome**: Effective safeguarding practice is in place to adequately protect vulnerable CYP.*

13. The CCGs need to assure compliance with the DNA policies across the health provider agencies.
    ***Outcome**: Vulnerable CYP who DNA health appointments are appropriately identified and managed.*

14. Acute Trust 1 needs to ensure that staff are compliant with the safeguarding procedures in respect of Discharge Planning.
    ***Outcome**: All CYP who have child protection concerns have a discharge plan in place before leaving hospital*.

15. All agencies to ensure that appropriate senior representation attends strategy meetings/discussions and adequate information is provided to ensure informed debate.
    ***Outcome**: Strategy meetings make effective decisions based on enquiry, challenge and adequate information*

16. Bexley CCG needs to ensure that the actions relating to acute Trust 2 are transferred to the legacy bodies.
    ***Outcome**: Learning from this SCR continues to be actioned and embedded into practice within this geographical area*.

17. BSCB need to review its monitoring process in relation to actions and recommendations from SCR's.
    ***Outcome**: Lessons from SCRs are embedded into practice.*

8.0 Background reading/References

Bexley Local safeguarding Children Board: Serious case Review, Executive summary; Child A 2010

Brandon M, et al (2009); Understanding Serious case Reviews and their impact: A biennial Analysis of serious Case reviews 2005-07 DCSF.

Brandon M et al (2011); A study of recommendations Arising from Serious Case Reviews 2009-210 DoE.

Brandon M et al (2012); New Learning from Serious Case Reviews; a two year report for 2009-11 DoE.

CEMACH: Confidential Enquiry into Maternal and Child Health; May 2008
Why Children Die: A pilot study 2006.

DoH: Chief Medical Officer's Letter.
Vitamin D -Advice on supplements for at risk groups.
London: DoH 2012

Gambril, Ed (2005) ; Decision making in Child Welfare: errors and their context.
Children and Youth Service review.
Vol 27.

Great Ormond Street Hospital 2012: Post Mortem Report for Baby F June 2012.

HM Gov ; Working Together to Safeguard Children 2012.

HM Gov ; Working Together to Safeguard Children 2013.

Laming Inquiry (2003): Victoria Climbie Inquiry; report by Lord Laming . HM Gov

LSCB Safeguarding Procedures (specifically Discharge planning, DNA processes, Section 47 procedure, Rapid response and Chid Death Procedures):
Bexley LSCB (2009)
London LSCB (2010)
Kent and Medway LSCB (2007)

Munro, E (2011); The Munro review of Child protection: Final Report, A Child Centred System.
DoE.

National Institute for Health and Clinical Excellence : march 2008
Antenatal care Routine care for the healthy pregnant woman.
NICE clinical guidance 62.

National Institute for Health and Clinical Excellence : march 2008
Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households.

NICE public health guidance 11

NHS Commissioning Board (2012) Arrangements to secure children's and adults safeguarding in the future NHS: the new accountability and assurance framework-interim advice.

Rickets: medicinenet.com/rickets/article

RCPCH 10: Safeguarding Children and Young People: Roles and Competencies for Healthcare Staff: Intercollegiate Document.

UK WHO Growth Chart for Boys 0-4 years.