Bedford Borough Safeguarding Children Board

Serious Case Review

Child A1301

October 2014

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Executive Summary

Reason for the Review

This Serious Case Review is about Child A, a white British child who died at the age of 19 months as a result of an unexplained non-accidental head injury. Child A's Mother and her partner (father of Child A's younger half sibling) were arrested, but it has not been possible to establish who caused the fatal injury. The legal proceedings regarding the future care of the surviving half sibling concluded that Mother and /or her partner had caused the injury. There is no evidence to suggest that any professional could have predicted or prevented this sad death**.**

Review Process

This Serious Case Review has been undertaken using the SCIE Learning Together methodology[i]. The process was led by two reviewers, one of whom was independent from all agencies, and the other an experienced safeguarding professional whose agency services were not part of the Review. These reviewers were responsible for writing the report. A panel of senior managers and many of the professionals who had direct involvement with Child A and their family oversaw the Review. The Review Panel made a significant contribution by taking part in interviews and attending meetings. We are grateful for their thoughtful and open contribution, and their willingness to learn lessons from this sad incident to improve future practice. Child A's Father also made a significant contribution to the Review and we want to also thank him for this. Child A's Mother and her partner were invited to contribute their views, but no response was received from them.

Child A Family Circumstances

Child A lived for the first four weeks of life with both parents, but they separated acrimoniously when Child A was 4 weeks old. Mother and Father are both White British and they both experienced reasonable economic and social circumstances, and had supportive and available families. Mother started a relationship with a friend of both parents soon after she separated from Father and they had a child when Child A was 18 months old. There is little information about Mother's partner, except that he is also White/British and worked full time.

Contact with Professionals

Child A's parents were on the point of separating when Mother discovered she was pregnant. She initially decided to have a termination, but discovered that she was already 30 weeks pregnant, and the parents decided to remain together. Child A was born, and the parents almost immediately separated. The parent's relationship was acrimonious and there were allegations of domestic disputes by Mother, which were not substantiated by the police and one allegation was found to have been falsely made by Mother which led to police action.

Mother started a new relationship soon after she and Father had separated. There were then consistent disputes regarding contact arrangements for Child A. An anonymous caller to Crimestoppers in November 2011 alleged that Mother was drink driving with Child A in her car and using a false driving licence. When Child A was three months old Mother sought help from her GP regarding anxieties about returning to work which she claimed was caused by Father's abuse.

Father took legal action regarding the difficulties with contact and also sought a shared Residence Order through Private Law proceedings. During these proceedings Mother told the CAFCASS worker that Father was a cannabis user, and Father said that Mother misused alcohol. These allegations were taken seriously, but subsequent drug and alcohol testing were negative. The issue of contact was seemingly resolved, but it remained acrimonious. Father provided a large amount of information as part of the Private Law proceedings that Mother had been aggressive and violent in the past and, had problems with alcohol. She disputed these issues, and the shared residence was not granted.

Mother became pregnant when Child A was 10 months old and she did not seek antenatal care until very late into her pregnancy. The reason for this remains unclear, but she said that she had again not realised that she was pregnant. The Midwife who saw her had concerns that she smelt of alcohol, and made a referral to Children's Social Care. They carried out an Initial Assessment which led to no further action, because the concerns were not substantiated and there was no evidence that Mother needed further support. Mother and her partner had routine contact with health professionals, and there was no reason for any other professional contact with Child A or their half-sibling in the weeks before the critical incident.

Up until Child A's death there were no concerns about Child A or the half-sibling, and there is no evidence that professionals could have predicted or prevented Child A's death. What this case does highlight is the professional response to families involved with universal services, about which there are low level concerns and the importance of professional curiosity. It also raises the importance of good quality information sharing to form a holistic picture of a child's life. If some of the gaps highlighted in the Findings below had been addressed a fuller picture of this family's life would have been known.

Finding 1: The acceptance of parental explanations has prevented professional curiosity and challenge

Partnership practice with parents and building relationships is an important part of safeguarding and support because parents are often experts in their child's life. However, it is critical that professionals maintain a level of healthy scepticism and respectful uncertainty in their work (Laming 2003). In order to achieve this professionals need to think about the information parents provide and challenge discrepancies and inconsistencies. In this case Mother provided discrepant and inconsistent information to a number of professionals, which was not actively checked or challenged. For example, during the Initial Assessment undertaken during Mother's second pregnancy, she disputed information that the midwife had provided, asserting that it was the midwife that was mistaken; she gave untrue information about Child A's contact with their Father, saying she had organised it because she believed that it was important they developed an effective relationship and she denied having drunk any alcohol, despite smelling slightly of alcohol being the reason for the assessment. This information was recorded in the assessment without comment, or a professional view being provided. It is much safer for children, young people and their families if challenge of what is reported by parents is built into processes such as supervision and decision making, but also into cultural expectations which recognise that asking questions and seeking explanation from parents is something to be valued. A high reliance by professionals on self-report by parents brings with it significant risks of proceeding on false information. The Bedford Borough Safeguarding Children Board is asked to consider whether there is a collective view about the prevalence of this issue and the scale of change needed around challenge with families; whether there is enough known about the perspectives of the workforce on this issue and how the Board could promote a culture where professionals are supported to be challenging when necessary.

Finding 2: Recognising the potential consequences of Mothers who book late into their pregnancy is important

Delayed antenatal booking presents medical and service challenges, leaving only a short window for the relevant health checks to be undertaken, and arrangements for the birth to be made. This case represents the paradox whereby women who delay booking for antenatal care – for whom there may be increased psychological and other risk factors – are *less* likely to have their emotional and psychological needs investigated and responded to, due to the urgency of their medical needs. There is no evidence that Mother was asked follow up questions about the delay or whether the issue of a concealed pregnancy, ambivalence about this baby or being a parent were considered and assessed. There are significant potential risks for babies if we do not balance the need for medical issues with psychosocial ones where women delaying booking for antenatal care. The Bedford Borough Safeguarding Children Board is asked to consider whether any previous work has been carried out in this area, whether there is a clear pathway for professionals to follow regarding delayed first presentation/ late booking and what action can be taken to address these issues.

Finding 3: The Importance of routine enquiries regarding domestic abuse in the pre and post natal period can get lost where there are no other obvious risk factors

The Department of Health introduced Routine Enquiry regarding domestic abuse in all health settings because the risk of women being subject to domestic abuse is heightened when they become pregnant or immediately after childbirth and the potential impact on the baby and mother is significant. There is no evidence that Mother was asked by health professionals about domestic abuse, and the Review Panel were told that this was in large partly because there appeared to be no other relevant risk factors present. Given the long term impact of domestic abuse on children and adults it is essential that domestic abuse is detected early on and that those affected are provided with an active and sensitive response. The Bedford Borough Safeguarding Children Board is asked to consider whether they are confident that all antenatal and postnatal professionals are aware of the importance of the sensitive and routine asking of all men and women about domestic abuse, whether those professionals feel equipped to ask these questions and how to respond appropriately and what action they could take to address these questions.

Finding 4: **Preconceived ideas about fathers as either "good" or "bad" and the influence on the professional response**

There is evidence from research that suggest there is 'fixed thinking', in the professional response to men in safeguarding and support services which has led to fathers or father figures being perceived in polarised ways as either primarily 'good' men (good dads) or 'bad' men (bad dads). The research showed that beliefs linked directly to whether fathers were thought of by professionals as reliable or unreliable, trustworthy or untrustworthy and therefore the extent they were included as sources of knowledge about children's lives, in assessments and in decision making. Child A's Father was at times viewed as abusive and controlling in his contact with professionals. For example, in the Private Law application to the Courts for a Residence Order Father provided a large amount of information to the court about his concerns about Mother's drinking, mental health and aggression. This was viewed as evidence by the Court of his controlling behaviour, and not taken account of. Fathers are important to children, and it is critical they are given a voice. It is therefore imperative that fixed views about men do not get in the way of providing an individual response based on the needs of children. The Bedford Borough Safeguarding Children Board is asked to consider whether they have any existing data about the involvement of fathers in decision making from early intervention to safeguarding, whether they are aware of the Father

Matters Initiative introduced by the coalition Government to address these issues nationally and what the Board could offer in terms of addressing this issue.

Finding 5: Professionals missed opportunities to share information with health colleagues

This Review highlights the important role that GP's, Health Visitors, Midwives and all other health professionals' play in sharing information which will aid other professionals to undertake the early identifications of need. Mother shared with her GP that she wanted a termination, but she found that her pregnancy was too far advanced. Although this was an extremely personal decision for her, it was the view of the Review that the GP should have assessed whether it was appropriate to share this information with Health professionals because these parents had not intended to be parents, and were due to take on this role in a matter of weeks. The impact of this on attachment and relationships may need to have been assessed. The Bedford Borough Safeguarding Children Board is asked to consider whether they are aware that information sharing by GPs to the wider multiagency network is an issue of concern beyond this case, how they might establish whether this is the case and what strategies they might employ to address it.

Alongside these Findings there were three additional issues that the Bedford Borough Safeguarding Children Board was asked to consider:

The acknowledgement of the emotional impact of child deaths and subsequent Serious Case Review on professionals: The professionals who were involved in this case felt that the way in which they were informed about the death of Child A and the subsequent instigation of the Serious Case Review was unsupportive, unconsidered and disjointed leaving them feeling upset and deskilled. There was the exception of the Midwifery staff who felt well supported by their manager. The Bedford Borough Safeguarding Children Board were asked to consider what could be done about this for future reviews.

In this case the Father felt unable to share his concerns about Mother's parenting and the potential impact on Child A because he was worried about being involved with "social services". If this information had been shared early on it may have influenced the professional view of this family. The Bedford Borough Safeguarding Children Board is asked to consider whether this is an issue beyond this case which requires action.

Crimestoppers – Clarification is required about to properly identify, utilise and share safeguarding intelligence raised via this mechanism. In November 2011 Crimestoppers received information that Mother was drink driving in the local area, with a child in the car. There does not appear to be a mechanism for ensuring that this information is shared with the appropriate police section who can address the safeguarding aspects. This was a serious allegation about the needs and circumstances of a child and there should be a mechanism for Crimestoppers intelligence reports to go to the appropriate police section.

1 INTRODUCTION

Reason for the Serious Case Review

1.1 This Review was instigated because Child A1301 (hereon referred to as Child A) died at the age of 19 months as a result of an unexplained non-accidental head injury. On the 16th April 2013, the Mother took Child A to the GP surgery with a three day history of diarrhoea and vomiting. Child A was seen again later the same day at the out of hours GP service with the same complaint. The examination of Child A on both occasions was reported as normal and the Mother was advised to give Child A additional fluids.

Child A was admitted to Hospital on 21 April 2013 after being found in the cot by Mother's partner possibly fitting. A CT scan was undertaken and revealed a severe head injury. Child A was promptly transferred to Addenbrooke's Hospital where they underwent surgery to reduce the pressure on their brain. Child A was subsequently transferred to their paediatric intensive care unit, and died on 24 April 2013. The medical view was that the injury was likely to have been caused by extreme force, akin to a car travelling at 60 miles per hour and stopping suddenly. Neither Child A's Mother nor Mother's partner could provide an explanation for this injury which had occurred whist Child A was at home cared for by them. They were arrested, and bailed, and they currently do not face any criminal charges. It has not been possible to establish who caused the injury to Child A. The legal proceedings regarding the future care of the half-sibling concluded that Child A had suffered non-accidental head injuries caused by the Mother or Mother's partner. This hearing also concluded that both had lied about the circumstances leading up to Child A being hospitalised, Mother's alcohol misuse, and also concluded that there was no evidence that either adult had not provided appropriate care for Child A or their half-sibling prior to the incident.

There is also no evidence to suggest that any professional could have predicted or prevented this sad death.

1.2 The Bedford Borough Safeguarding Children Board (BBSCB) Serious Case Review Panel and Independent Chair of the Bedford Borough Safeguarding Children Board agreed that this case met the criteria for a Serious Case Review as per Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 because Child A had died and abuse was suspected.

1.3 Working Together 2013[ii] requires that Serious Case Reviews should be conducted in a way which:

- recognises the complex circumstances in which professionals work together to safeguard children;
- seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

LSCBs may now use any learning model which is consistent with the principles in the guidance, including the systems methodology recommended by Professor Munro[iii]. The BBSCB agreed to undertake a review using the SCIE (Social Care in Excellence) Learning Together [iv]methodology.

Time scale for the SCR

1.4 It was agreed that the Review would cover the period of time from when Mother came into contact with professionals because she was pregnant with Child A, in June 2011, to the day of the critical incident, 21 April 2013.

The Review was commissioned in October 2013 and completed in October 2014.

The Family

1.5

	Relationship to Subject	**Age at time of critical incident**	**Ethnicity**
Child A1301	Subject of the review	19 months	White/ British
Child B1301	Half-Sibling	1 month	White/ British
	Mother	26	White/ British
	Father	28	White/ British
	Mother's partner, Father of Child B1301	21	White/ British
	Maternal Grandmother (MGM)		White/ British
	Paternal Grandmother (PGM)		White/ British
	Paternal Grandfather (PGF)		White/ British

Succinct summary of case

1.6 The family was largely known to routine, universal services and as a result little was known by professionals about the lived experience of Child A, their relationship with Mother, Father, Mother's partner and extended family. The parents were involved with routine services, except for some contact with the Police and an Initial Assessment undertaken in April 2013. Child A therefore had little direct contact with professionals, and when seen for routine health appointments and the Initial Assessment undertaken in April 2013 the available evidence was that Child A was well looked after, had a good relationship with their Mother and engaged with professionals. Mother's partner had no contact with professionals when he was caring for Child A so no agency was able to comment on his relationship with Child A. Mother's partner started a relationship with Mother when Child A was 8 weeks old. With the exception of maternity staff, who described their contact as routine, no

professional had any contact with him or saw him with Child A and his half-sibling who is the partner's biological child.

1.7 Mother reported during the Initial Assessment that she had a good relationship with her own extended family and it became clear during the contested residence order proceedings in May and October 2012 that she had a close relationship with her Mother, Child A's Maternal Grandmother. Mother also reported at this time that she was living in the village where she had been brought up and had friends and accessed local resources such as the mother and toddler group, but there was no objective evidence of this. She also said she had a horse which she had owned for 23 years and which was stabled in the village.

1.8 Father reported a close relationship with his parents, and they tried to help when Mother and Father were separating. The Paternal Grandparents subsequently supported Father during contact and Father reported that they were subjected to aggression by associates of Mother during contact visits. No professional had contact with the extended family.

1.9 Child A's parents were on the point of separating when Mother discovered she was pregnant. She initially decided to have a termination, but discovered that she was already 30 weeks pregnant. Child A was born, and the parents almost immediately separated. The parent's relationship became acrimonious and there were allegations of domestic abuse by Mother.

1.10 Mother started a new relationship soon after she and Father had separated. There were then consistent disputes regarding contact arrangements for Child A. An anonymous caller to Crimestoppers in November 2011 alleged that Mother was drink driving with Child A in her car and using a false driving licence.

1.11 Father took legal action regarding the difficulties with contact and also sought a shared residence order through private law proceedings. The issue of contact was seemingly resolved, but it remained acrimonious. Father provided a large amount of information as part of the Private Law proceedings that Mother had been aggressive and violent in the past, had problems with alcohol. She disputed these issues, and the shared residence was not granted.

1.12 Mother became pregnant when Child A was 10 months old and she did not seek antenatal care until very late into her pregnancy. The reason for this remains unclear, but she said that she had again not realised that she was pregnant. The Midwife who saw her had concerns that she smelt slightly of alcohol, and made a referral to Children's Social Care. They carried out an Initial Assessment which led to no further action, because the concerns were not substantiated. Mother and her partner had routine contact with health professionals, and there was no reason for any other professional contact with Child A or their half-sibling in the weeks before the critical incident.

Timeline of Key Professional Contacts

Date	Incident
September 2010	Father and Mother started a relationship.
13 June 2011	Mother went to GP 1 because she had discovered she was pregnant. Mother provided information to GP 1 who calculated that she was 19

	weeks pregnant. She requested a termination and the GP organised this.
June 2011	Mother and Father attended a private clinic as a result of GP referral and were told that because the pregnancy was of 30 weeks gestation it could not be terminated. The parents had been due to separate, but they agreed they would remain together and be parents for the unborn baby.
21 June 2011	Mother went back to her GP surgery and saw GP 2 who she told that she was unable to terminate the pregnancy and GP 2 made a referral for antenatal care.
7 July 2011	Mother was booked for antenatal care at 32 weeks pregnancy.
1 September 2011	Child A was born.
6 September 2011	Midwives visited and there were no concerns, Mother, Father and Child A was seen and all was described as well.
22 September 2011	Health Visitor – routine visit. Only Father seen, Mother and Child A not present.
October 2011	Mother and Father separated acrimoniously.
November 2011	Mother started a new relationship with an old friend of both parents.
16 November 2011	Mother telephoned the Police alleging that Father had been outside her house, had scratched her car, and harassed her through text messaging. Father was arrested and charged with criminal damage, which he was later exonerated of, and Mother was subsequently charged with providing a false statement.
16 November 2011	Father was arrested and charged with the use of threatening behaviour.
18 November 2011	The Police made a referral to Children's Social Care regarding the two incidents in November. In line with the existing threshold criteria it was agreed that no further action was necessary and Father had bail conditions imposed not to contact Mother.
30 November 2011	Mother and Father had a dispute regarding contact arrangements and Mother called the Police. No action was taken and the bail conditions remained.
30 November 2011	Anonymous information was received by Crimestoppers alleging that Mother was driving with Child A in the car after consuming two bottles of wine and using a counterfeit licence. This information was passed on to the Traffic Police who looked for her and the car, without success.
25 January 2012	Mother visited GP 3 and asked for a sick note because she said she had separated from her partner who had been abusive to her. She said that she could not return to work because her partner worked in the same place and she was having panic attacks. She was diagnosed with an anxiety state, given a two week sick certificate and Propranolol[v] was prescribed. She was seen twice more by the same GP, and her sick certificate was extended to May 2012.
30 March 2012	Father made a private law application for a shared residence order.

30 April 2012	Father was interviewed by a CAFCASS (Children and Family Court Advisory and Support Service) Officer. He discussed the conflicts regarding contact and provided details of an incident where he was threatened by a group of men when he went to collect Child A.
30 April 2012	The Police were made aware of allegations regarding Father's cocaine use, and a referral was made to Children's Social Care. This was reviewed by a Team Manager and led to no further action.
16 May 2012	Mother was interviewed by a CAFCASS Officer. She alleged that Father had used cocaine in the past, and was concerned he still did. She agreed to regular contact, but said she was against shared residency, saying it was not in Child A's best interest.
22 May 2012	The parents were seen by a CAFCASS Officer at Bedford County Court at the First Hearing. Father made allegations regarding Mother's alcohol use. They attended a Separated Parents Information Programme and a way forward for contact was agreed. The shared residency order application could not be completed because of the allegations of Father's drug use, and counter allegations of Mother's alcohol use, tests for both were agreed. Father filed an extensive body of evidence for the Hearing, making significant allegations about Mother.
26 May 2012	The Police were called by Mother regarding Father taking photographs of her car. No action was taken and a domestic abuse referral was sent to Children's Social Care. Seen as routine reporting and no action taken by Children's Social Care.
17 August 2012	Mother was arrested for making a false statement regarding the car scratching incident in November. No action taken.
10 October 2012	Final Court Hearing. Father filed a large number of responses to existing queries, on top of the file he had already submitted. He provided further information regarding concerns about Mother and her alcohol use. This was viewed by the court as evidence of his controlling nature. The Judge found in favour of Mother regarding the shared residency order. The financial cost to both parties was significant.
26 February 2013	Mother went to the maternity unit of the local hospital at 35 weeks pregnant because she was concerned about reduced fetal movements and backache. Mother reported that she had been aware of the pregnancy for two months and had seen the community Midwife three times. There was no record of this. The Midwife was concerned that Mother smelt slightly of alcohol and she made a referral to Children's Social Care using the Common Assessment Framework (CAF).
27 February 2013	CAF sent to Children's Social Care outlining Mother not seeking antenatal care despite knowing she was pregnant for two months and also smelling slightly of alcohol.
5 March 2013	Home visit made by a Social Worker to carry out an Initial Assessment. Mother disputed the information about the delay in booking or alcohol use. Child A was seen, good attachment with Mother noted and home conditions assessed as suitable. Mother's partner not present. Case closed.

7 March 2013	Social Worker telephoned the Midwife and said that the Mother had disputed the information provided regarding the delay in booking and case to be closed.
22 March 2013	Child B born.
23 & 27 March 2013	Midwives visited and there were no concerns, Mother, her partner (father of the baby) and baby all seen and all was described as well.
16th April 2013	Child A seen by GP with diarrhoea and vomiting Later on the same day Child A was seen by the out of hours GP services with diarrhoea and vomiting. The examination on both occasions was normal and Mother was advised to give Child A additional fluids.
19 April 2013	Father attended GP to follow up communication he had with the surgery about wanting knowledge of Child A's medical care and to be involved in decision making. He confirmed he had parental responsibility and his solicitor followed this up.
April 2013	Father wrote to Mother and her partner suggesting that he will be undertaking a further private law application.
21 April 2013	Child A was taken to hospital by ambulance after he was found in their cot by mother's partner. It was thought he was 'fitting'.
21 April 2013	Child A transferred to Addenbrookes.
24 April 2013	Child A died from a significant head trauma.

Methodology

1.13 This Serious Case Review has been undertaken using the SCIE Learning Together methodology[vi]. The focus of a case review using a systems approach is on multi-agency professional practice. The goal is to move beyond the specifics of the particular case – what happened and why – to identify the deeper, underlying issues that are influencing practice more generally. It is these generic patterns that count as 'findings' or 'lessons' from a case, and changing them should contribute to improving practice more widely. Data comes from semi-structured conversations with the involved professionals, case files, contextual documentation from organisations and the family who are the subject of the review. A fundamental part of the approach is to talk with staff to understand what they thought and felt at the time they were involved in the case, avoiding hindsight as much as possible. It is vital to try and make sense of what factors contributed to their actions at the time and to the decisions they made. This is known as 'local rationality'. The appraisal of practice is then made in the context of those contributory factors.

The Lead Reviewers

1.14 This review was undertaken by Jane Wiffin who is a SCIE accredited Lead Reviewer and Anneliese Hillyer-Thake who has undertaken the SCIE training and has been mentored by Jane Wiffin throughout the process.

Jane Wiffin was the independent Lead Reviewer. She is a qualified Social Worker who has extensive experience of working in safeguarding. She is an experienced Serious Case Review Author and Chair, having undertaken 22 reviews. She is an accredited SCIE Learning Together Reviewer. She is independent from all the agencies involved in this review.

Anneliese Hillyer-Thake is Head of Safeguarding for the East of England Ambulance Service NHS Trust. In this role she is responsible for contributing to Serious Case Reviews for Local Safeguarding Children's Boards across the Eastern Region. She has considerable experience in undertaking Serious Case Reviews.

The Review Team

1.15 The Review Team consisted of a team of senior representatives from local agencies who had no direct dealings with the case. They analysed the conversations and documents, identified key practice episodes and contributory factors and helped to make sense of the key Findings. This report is the shared responsibility of the Review Team in terms of analysis and conclusions, but was written by the joint Lead Reviewers.

Name	Agency
Roseanne Johnstone	Interim Head of Social Work, Bedford Borough Council
Helena Hughes	Designated Nurse for Safeguarding Children, Bedfordshire Clinical Commissioning Group
Karena Thomas	Detective Superintendent, Bedfordshire Police
Dr Wendy Kuriyan	Designated Doctor for Safeguarding Children, Bedfordshire Clinical Commissioning Group
Dr Abdullah Khan	Named GP for Safeguarding Children, NHS England / Bedfordshire Clinical Commissioning Group
Dawn Andrews	Head of Service for Safeguarding Children, South Essex Partnership Trust
Jackie Scott	Matron Paediatric Named Nurse Safeguarding Children, Bedford Hospital
Sally Stocker	Business Manager, Bedford Borough Safeguarding Children Board

The Case Group

1.16 The members of the Case Group are the professionals who worked with or made decisions about the family, and who had individual conversations with the Lead Reviewers. The Case Group comprised of 20 people (although not all these people attended case group meetings). They met with the Review Team on four occasions to share in the analysis, identification of contributory factors, and to comment and contribute to the final report. Individual sessions were held with some professionals, either because they could not make the case group meetings or to clarify data.

Family Involvement

1.17 Mother, Father and Mother's partner were all invited to contribute to the review. Mother and Mother's partner did not reply and therefore they have not contributed. The Lead Reviewers met with Father on three occasions and he provided a great deal of information as well as written material, based on his correspondence with professionals and particularly material related to his private law application. He also read the final report.

Structure of the Review Process

1.18 The Review Team met on five occasions, including four times with the Case Group, and worked on the data, analysis of practice and the identification of the Findings and issues for BBSCB consideration.

Sources of data

1.19

- Semi-structured conversations between the Lead Reviewers and 16 members of the Case Group;
- The semi-structured conversations with Father and materials provided by him and his solicitor;
- Documentation: All necessary documentation was made available to the Review Team ranging from case files, procedures, and police attendance records. This meant that the reviewers did an in depth review of all the relevant information held during the period under review by Children's Social Care, GP surgery, Police, CAFCASS, Health Visiting and Maternity Services.

2 PROFESSIONAL PRACTICE APPRAISAL

2.1 This case involves the routine response of agencies to Child A from when his Mother discovered she was pregnant in June 2011 to Child A's death in April 2013. The Author begins by capturing the appraisal that the Review Team made about the practice response to this case, given what was known and knowable at the time. The Findings that follow hope to provide an explanation of the "why" questions, outlining what got in the way of professionals being as effective as they wanted to be.

2.2 It is always difficult for those professionals who were directly involved with a child who dies unexpectedly. The professionals we spoke to expressed this very clearly and these feelings were compounded for them by the news that there would be a Serious Case Review. This caused anxiety for many and many of the professionals told the Review Team that this anxiety was not sufficiently acknowledged or addressed by their organsiations **see the additional learning section**. Despite this, all the professionals who had contact with Child A and the family took part willingly and intelligently, because of a keen desire to understand what had happened and improve practice for the future. The Review Team is grateful to them for being open and helping to make sense of the case and the context in which practice took place.

2.3 It is quite clear that this was an unexpected death and there were no indications that either Mother or her partner was likely to harm Child A. The circumstances which led to Child A's sad death remain unknown. In the recent Finding of Fact Hearing for the care proceeding regarding the half sibling, the presiding Judge concluded that Mother and Mother's partner had not given a true account of the events that led to the death, and that Mother had lied about her alcohol misuse and her partner had not been honest about his knowledge of this.

2.4 Mother went to her GP in June 2011 and said was pregnant. She provided information which led GP 1 to assess that she was 19 weeks pregnant and she asked GP 1 to organise a termination. There is little information about why she decided to have a termination and the GP did not record information about this. Father told the reviewers that it was because the relationship had become fractious and they were about to separate. When Mother and Father attended the termination of pregnancy services, Mother was found to be 30 weeks pregnant and therefore they could not terminate the pregnancy.

2.5 Mother returned to her GP surgery and saw GP 2. There is no recorded conversation between the GP and Mother about how she felt about the pregnancy continuing or, her and her partner's emotional readiness to be parents. This should have taken place. An antenatal referral was made, which did not include the information regarding Mother planning a termination, but being too late into her pregnancy and consequently no other professional knew about this start to Child A's life or had an opportunity to consider its meaning for Child A or Mother. Although this was an intensely personal issue, the GP should have made an assessment of whether sharing this information as part of the health response to antenatal care would be appropriate in the context of Mother and the unborn child's wellbeing. (**See Finding 5**). The Healthy Child Programme[vii] alongside NICE Guidance[viii] makes clear the importance of the early assessment of maternal and paternal emotional wellbeing (**see the additional learning section).** This should include a consideration of the early risk factors associated with impaired outcomes for children later in life, such as ambivalence about a pregnancy, unstable partner relationships and intimate partner violence. It is unclear how well Mother and Father were

prepared for parenthood, and there should have been a greater consideration of the implications for the care of this baby, the potential impact on the attachment relationship and Mother and Father's health and well being.

2.6 Mother saw a Midwife at 32 weeks pregnancy. She explained that she had not realised that she was pregnant, which was why she was booking her antenatal care so late. The Midwife was not aware that Mother had sought a termination. All action was taken to ensure Mother's medical needs were met, but there is no recorded discussion or assessment of the implications of delayed first presentation/late booking, or exploration of the reasons for it. Delayed first presentation/late booking is known to be a significant risk factor, and even in the context of a Universal provision there should have been more professional curiosity about this very delayed first presentation/ late booking and the potential impact on parent-child attachments and the potential impact on Mother's mental health. **(See Finding 2).**

2.7 When Child A was born, the family were visited by health professionals as would be expected. These were routine visits where family relationships appeared to be positive, and the evidence was that Mother was coping well with the new baby. There is no recorded evidence of whether she was asked about her emotional wellbeing, in line with NICE Guidelines[ix] or whether she was asked about domestic abuse **(See Finding 3).** Father described later in his court statement that at this time Mother was drinking, and there were fights between them. He did not share this with any professionals at the time (**see additional learning**).

2.8 The parents separated a month after Child A was born, and Mother started a new relationship with mother's partner who was an old friend. There were tensions between Mother and Father about contact arrangements, and Mother called the Police twice to report text and verbal harassment and damage to her property by Father (which was subsequently proven to be untrue). Father confronted mother's partner about an allegation that he had attempted to defraud him regarding the sale of his house (mother's partner was an estate agent at this time) and Father was arrested for threatening behaviour. These incidents were dealt with appropriately by the Police, and they shared information with Children's Social Care as would be expected. This was routine reporting and in line with the existing thresholds for the provision of services this led to no action beyond being held on file. During this time Crimestoppers received an anonymous referral regarding Mother drinking and driving (two bottles of wine) with Child A in the car. This was sent to the traffic division, who immediately looked for Mother on the road, but this information was not shared with the Public Protection Unit, the Police agency responsible for addressing potential harm to children, as would be expected, given the risks this posed to Child A. It was a missed opportunity to develop a clearer picture of the circumstances in which Child A lived. Despite extensive efforts to make sense of why this gap exists, it has not been possible to do so. **(See additional learning).**

2.9 When Child A was three months old, Mother told GP 3 that she was having panic attacks, which she said were caused by the Father threatening her. Mother said that she and Father had separated, but she was worried about returning to work because he worked for the same organisation. She was diagnosed as having "an anxiety state", medication was prescribed, and a sick note given, which was subsequently extended for four more months by GP 3. The GP ascertained that Mother was in a safe place, living with Maternal Grandmother and the police were involved. There is no recorded discussion of the implications of either the anxiety state, or the allegations regarding threats on the wellbeing of a three month old baby as would be expected. This information was not shared with the Health Visitor and it is the view of the Review Team that the Health Visitor should have been told of the pressures

on this new Mother with a young baby **(see Findings 3 and 5) .** This was a missed opportunity to develop a clearer picture of the circumstances in which Child A lived and the support that might be needed. There was no reason for Mother and Child A to have contact with any other professional during this time. The GPs later explained, as part of this review, that they no longer have the same contact or alignment with Health Visitors as in previous years, where they would have regularly met with Health Visitors assigned to the practice. The national health visiting specifications states that the service should be delivered so that there is a named Health Visitor linked to each GP practice and that they will facilitate an agreed schedule of regular contact meetings for collaborative service delivery. This review has enabled the practice to strengthen information sharing with the Health Visitor and Midwife.

2.10 In March 2012 Father made a Private Law application for a contact order and a shared residence order, (and he paid all of his own legal costs). This was prompted by the difficulties he was having in seeing Child A, and indeed he alleged that on one occasion he was threatened by a group of men when he attended an agreed contact session. Mother and Father were assessed promptly by CAFCASS and interviewed by a CAFCASS Officer at the first hearing in May 2012. Mother made an allegation that Father had used cocaine in the past, and she was concerned he was still doing so. Appropriately, a drug test was ordered (paid for by Father), and was subsequently found to be negative. There is no evidence that Father ever used cocaine. Father made allegations about Mother's alcohol misuse, and she was also tested, and this also proved to be negative. The contact arrangements were agreed and CAFCASS closed the case, as would be expected, at this point.

2.11 The first hearing for the Shared Residence Order was heard in May 2012 and Father made a number of allegations about Mother to the court. This information included allegations of Mother's misuse of alcohol, her lying about when she discovered that she was pregnant and that she had attacked Father physically and self harmed with the intention of telling the Police that Father had hurt her. He also provided a large quantity of texts from her – he did not provide the corresponding replies, personal letters and pornographic pictures of Mother he had found on his computer. Mother made allegations of domestic abuse by Father. Father was told by his solicitor that the evidence that he had provided was viewed within the court proceedings as further evidence of his controlling behaviour in the context of domestic abuse. It is of concern to the Review Team that the court did not ask for an assessment (Section 7 report) to be undertaken, given the concerns raised about both parents. The implications for the care of Child A do not appear to have been sufficiently considered, and Father appears to have been sidelined, and his concerns dismissed. This was not appropriate. (**See Finding 4).** This was a further missed opportunity to develop a clearer picture of the circumstances in which Child A lived.

2.12 In February 2013 Mother went to hospital, said that she was pregnant and concerned about reduced fetal movement. This was the first that any professional knew of the pregnancy which was assessed as being of approximately 35 weeks gestation. She told the Midwife that she had discovered that she was pregnant two months earlier, and had seen a Community Midwife on two occasions. This was checked with the Community Midwife a few days later who said that she had not had any contact with Mother. The issue of Mother's delayed first presentation/late booking for pregnancy was not explored further with her (**see Finding 2**) and there was no evidence that her emotional wellbeing was explored; in line with existing guidance[x] or whether she was asked about domestic abuse (**See Finding 3)**. The Midwife was concerned about this delayed first presentation/late booking and the fact that Mother smelt "slightly" of alcohol. She decided that a referral to Children's

Social Care was needed, and this was done via the Common Assessment Framework (CAF) the next day. This was a clear and proportionate response; however the Midwife did not have an opportunity to inform Mother that she was making a referral. The current concerns were clearly outlined, but the previous delayed first presentation/late booking for her first pregnancy was not mentioned as would have been expected.

2.13 The referral was responded to promptly and an Initial Assessment started. Mother was seen at home with Child A. Information about past concerns regarding the police notifications of domestic abuse was discussed, and the GP was asked for information regarding the wellbeing of Child A, but not asked about Mother's background. The assessment relied too heavily on Mother's own version of events – her "self report" that she did not drink alcohol, that the information from the Midwife was incorrect regarding how long she had known about the pregnancy, that Child A had regular contact with his Father and she had ensured that this took place. These were all unsubstantiated assertions (**See Finding 5**).

2.14 This Initial Assessment was only focused on the risk to the unborn baby, and not Child A. Father was not aware that the assessment of Child A had been undertaken. His views were never sought, despite him having parental responsibility, and at this point he had made allegations to court about his concerns regarding Mother's drinking, mental health and her potential aggression. This information would have challenged Mother's own self report of her circumstances, and would have provided a different picture regarding the risks faced by Child A and the unborn baby. The assessment concluded that there was no role for Children's Social Care and the case was closed. Given the information collected this was an appropriate response. The referring Midwife was informed of the outcome, of the history of domestic abuse, and that Mother disputed what the Midwife had said about the delayed first presentation/late booking. This dispute was not discussed, and therefore the likelihood that Mother was not telling the truth about her circumstances was not considered and the implications for the needs of either child not assessed in the light of this.

2.15 Child A's half sibling was born, and Mother and her partner were visited as would be expected by health professionals. There were no concerns raised as a result of these visits, which were described as routine with evidence that Mother was coping well with the new baby. Child A was seen and described as "lovely" and "thriving". Mother did not share that there was continued conflict with Father, or the threat of further costly legal action by Father.

2.16 Child A was brought to hospital with a slow heart rate and seizures in April 2013, and Child A was discovered to have a serious head injury. Although this review does not cover the care provided to Child A before they died, there is significant evidence that this was of a consistently high standard, and both hospitals Child A attended tried to do all they could to save Child A. The half-sibling was immediately safeguarded, and care proceedings sought.

2.17 It was a shock to all those professionals who had contact with Child A that they had died and that Child A's Mother and mother's partner were arrested on suspicion of having caused the injury that caused Child A's death. The impression was that this was an ordinary family who were respectable, and the available evidence was that both children were well cared for by Mother and Father and subsequently Mother and Mother's partner. The contact the family had with professionals was of a largely routine nature, and the only concerns were regarding disputes and harassment which led to Police action and one allegation regarding Mother smelling of alcohol

during her second pregnancy. In reality it has emerged that there were some concerns about Mother's alcohol use, about anxiety and aggressive disputes about contact, with both Father and Mother alleging domestic violence. It is the task of this review to try and understand why such a false image of Child A's circumstances remained. It appears that it was in part caused by some gaps in information sharing across the multi-agency network; (**see Finding 5**). Mother lied consistently about her circumstances, and she was not challenged about inconsistencies in the information she gave to professionals (**see Finding 1**). Father had concerns which he initially did not share because he did not want his child known to "social services" (**see the additional learning section)** and when he did provide information to court he was perceived as controlling, and so his concerns were minimised (**see Finding 4).** He was not included in the Initial Assessment that took place during Mother's second pregnancy and thus an opportunity to form a more holistic view of Child A's life was missed. These are important learning points for future practice, but there is no evidence to suggest that any professional could have predicted or prevented this sad death.

3 THE FINDINGS

In what ways does this case provide a useful window on the system?

3.1 The outcome of this case is unusual. Around 1 – 2 children a week are killed by their parents or carers[xi]. There is growing evidence regarding the profile of parents who kill their children, and there is often a coexistence of serious psychiatric disorders, violence and significant substance misuse. This blended family does not fit this profile. They lived in reasonable economic and social circumstances, and had supportive and available families. There were some known issues about conflict, alcohol misuse and a brief spell of anxiety as well as Mother's delayed first presentations/late bookings for her pregnancies. Up until Child A's death there were no concerns about Child A or their half-sibling, and there is no evidence that professionals could have predicted or prevented Child A's death. What this case does highlight is the professional response to families involved with universal services, about which there are low level concerns and the importance of professional curiosity. It also raises the importance of good quality information sharing to form a holistic picture of a child's life.

Analytic process for establishing systems findings

3.2 The aim of a Learning Together case review is to use a single case as a '*window on the system*', to uncover more general strengths and weaknesses in Child A protection system. A four-stage process of analysis is used to articulate how features of the case can lead to more general systems learning. The first is to look at how the issue manifested in the case, this will often be presented as one example, even if there are several such examples. This evidence comes from the analysis of the case and examination of key practice episodes.

3.3 The second step is to consider whether the issue observed in this case is 'underlying'. That is, that it is not a 'quirk' of the case, but is likely to represent practice in other cases and by other practitioners. The third step is to consider how geographically widespread and numerically prevalent the issue is within the system. Sometimes it is not possible within the scope of a review to establish this data. The sources for these steps will be information from the Review Team and Case Group, any performance data, national research and other reviews in a variety of combinations.

3.4 The last step is to articulate why this issue matters, what are the risks to the safeguarding system. Based on this finding, questions and considerations for the BBSCB are formulated.

3.5 Alongside the systemic Findings there was also some additional learning that emerged from this review and this is covered in section 4.

Categories of underlying patterns

3.6 The systems model that SCIE has developed includes 6 broad categories of underlying patterns. The ordering of these in any analysis is not set in stone and will shift according to which is felt to be most fundamental for systemic change. Not all the typologies will have a finding associated with them but they are designed to allow for structured enquiry as to what the data has revealed:

- Human biases (cognitive and emotional):

Are there common errors of human reasoning and judgement that are not being picked up through current case management processes?

- Family-professional interaction:

What patterns are discernible in the ways that professionals are interacting with different family members, and how do they help and or hinder good quality work?

- Communication & collaboration in responses to incidents:

Are there particular good or bad aspects to the patterns of how professionals respond to specific incidents (e.g. allegations of abuse)?

- Communication and collaboration in longer term work:

Were any good or bad patterns identified about ways of working over a longer period with children and families?

- Tools:

What has been learnt about the tools and their use by professionals?

- Management system:

Are any elements of management systems a routine cause for concern in any particular ways?

This review has prioritised five findings for the BBSCB to consider:

Finding	Category
Finding 1: The acceptance of parental explanation has prevented professional curiosity and challenge.	Family Professional Interaction
Finding 2: There is insufficient knowledge and understanding about the potential consequences of delayed first presentation/late booking on the welfare and mental health of the family.	Communication & collaboration in response to incidents
Finding 3: The message about the importance of routine enquiries to be made about domestic abuse in the pre and post natal period may have got lost where there are no other obvious risk factors.	Communication and collaboration in longer term work
Finding 4: Preconceived ideas about fathers as either "good" or "bad" influences potentially whether they are involved in assessments regarding their children. This means that important information about risks may be lost.	Human biases (cognitive and emotional)
Finding 5: Opportunities were missed to share information with health colleagues which would have allowed other professionals to undertake a more comprehensive assessment of the family's wellbeing and the couple's readiness for parenthood. If appropriate information is not shared with the multi-agency network this could lead to instances where there is an incomplete assessment of a child's wellbeing.	Communication and collaboration in longer term work
Additional Learning	
There is insufficient acknowledgement of the emotional impact of child deaths and subsequent Serious Case Review on professionals.	
In this case the Father felt unable to share his concerns about Mother's parenting and impact on Child A because he was worried about being involved with "social services". Does the BBSCB consider that this is an issue beyond this case which requires action?	
Crimestoppers – Clarification on how internal mechanisms properly identify, utilise and share safeguarding intelligence raised via this mechanism.	

Finding 1: The acceptance of parental explanation has prevented professional curiosity and challenge.

How did it manifest in the case?

3.7 Partnership practice with parents is important where there are concerns about children's welfare. Munro[xiixiii] in her review of child protection system highlighted the importance of developing effective relationships with parents, to achieve better outcomes for children. The concept of partnership practice has recently been defined as "Authoritative Practice" where professionals treat parents/carers with respect and empathy, but are also clear about appropriate and positive challenge.[xiv]

3.8 In this case there were a number of incidents where professionals relied on the self-reporting by Mother without challenge or without a clear search for corroborative evidence.

3.9 In February 2013 Child A's Mother attended hospital and told health professionals that she was pregnant with her second child and was worried about reduced foetal movement. At this time she was 35 weeks pregnant. Mother reported that she had not known she was pregnant until 8 weeks earlier, and she had seen a Community Midwife on two previous occasions. This was not the case, and although the Midwife who saw her could not find any information regarding these previous contacts, she did not challenge Mother about this discrepancy. The Midwife made a referral to Children's Social Care, because of the delayed first presentation/late booking and concerns that Mother smelt of alcohol. She included the information in the referral that Mother had reported seeing a Community Midwife but that there was no evidence that this had taken place. This information was provided without any professional comment or analysis and was not contextualised alongside her previous delayed first presentation/late booking.

3.10 The Social Worker discussed with Mother the issue of her delayed first presentation/late booking and how long she had known she was pregnant. Mother disputed the information provided by the Midwife. This issue was not analysed and the possibility that Mother was not telling the truth not acknowledged. Subsequently, the Social Worker contacted the Midwife to tell her that Mother disputed the information she provided, and said the Midwife had obviously misunderstood her. There was no discussion or analysis of this information, or discussion about what this might mean. This lack of reflection meant that Mother was seen as reliable, well engaged and trying her best to be helpful.

3.11 In reality, during the assessment interview, Mother provided information that was not true. She said that she did not have a problem with alcohol and that she had only smelt of alcohol because she had been to the pub, but not consumed alcohol, and this was believed. She also said that she had organised contact for Child A with Child A's Father because she recognised that it was important and that it was going well. This was also not true, and if contact had been made with Father or CAFCASS this would have been apparent. It is not always possible to triangulate all information provided as part of these routine assessments, but where this is the case, it must be made clear what the parents view is, and what the assessing Social Worker believes about it. What their professional judgement is about it. This is where "healthy scepticism" and "respectful uncertainty" (Laming 2003) plays a part.

3.12 There was a further opportunity to check the issue of parental self report in the Initial Assessment if it had been shared with the Midwife to check and confirm the content and analysis. She was the referrer and her agency was due to continue working with

Mother and her partner. The Midwife did not ask to see the assessment and it was not shared with her. The issue of partnership with parents has meant that there is a mistaken belief that parents must give permission for the assessment to be shared. In fact national guidance makes clear that the assessment is focussed on Child A and that if there are agencies who will remain involved after the assessment has completed, that information regarding the assessment should be shared with them, to enable them to complete their work.

How do we know that it is an underlying issue and not something unique to this case?

3.13 The Case Group told the Review Team that a reliance on parental self report was a key issue in their work. They told us that giving parents a voice in records and assessments was important, but they reflected that this might lead to a lack of healthy scepticism and respectful uncertainty (Laming 2003).

How common and widespread is this?

3.14 It is unclear how common and widespread this issue is in Bedford Borough as no data is collected about the extent of parental self report and its influence on decision making. This is a not an issue which is part of current auditing practice.

Why is it important?

"Working with family members is not an end in itself; the objective must always be to safeguard and promote the welfare of a child. The child, therefore, must be kept in focus"

3.15 Partnership practice with parents and building relationships is an important part of the assessment process, as parents are often experts in their child's life. However it is critical that professionals maintain a level of healthy scepticism and respectful uncertainty (Laming 2003). This is an active process of triangulating the information from different sources, and establishing ether there are discrepancies and what those discrepancies might mean (Morrison) for the child.

Finding 1: The acceptance of parental explanation has prevented professional curiosity and challenge.

It is much safer for children, young people and their families if challenge of what is reported by parents is built into processes such as supervision and decision making, but also into cultural expectations which recognise that asking questions and seeking explanation from parents is something to be valued. A high reliance by professionals on self-report by parents brings with it significant risks of proceeding on false information.

Arrangements put in place to recognise when there is insufficient challenge, and to increase the value given to challenge, are in the interests of families and professionals. Such arrangements can include ensuring time for in depth supervision, ensuring an independent uninvolved voice at key decision making meetings, managers modelling that challenge is acceptable, and showing how it can be done in a constructive way so that workers have more confidence in challenging parents.

Questions for the BBSCB

Is there a collective view at the Board about the prevalence of this issue and the scale of change needed around challenge with families?

Is enough known about the perspectives of the workforce on this issue? Is there a view that to challenge parents is to be judgemental? How could the Board promote a culture where professionals are supported to be challenging when necessary? Is there clarity about when assessments can and should be shared with multi-agency colleagues?

Finding 2: There is insufficient knowledge and understanding about the potential consequences of delayed first presentation/ late booking on the welfare and mental health of the family.

3.16 There is general recognition that delayed first presentation/late booking for antenatal care is a potential risk factor for the health and wellbeing of mothers and babies (Calder 2013). Despite this, there is a lack of both quantitative and qualitative research which addresses the phenomenon of delayed antenatal attendance. Where small scale research exists it shows that delayed first presentation/late bookers tend to come from disadvantaged groups such as Black and Minority Ethnic communities, women who are single and unsupported and women who are more socially deprived. The reasons for the delayed first presentation/late booking are often connected to this disadvantage, or a lack of knowledge or information about antenatal care. Mother and Father were not in any of these disadvantaged groups.

3.17 Research does also suggest the reason why some women fail to access antenatal care could be a rejection of the pregnancy or concealment. There is limited research into concealed pregnancy and even less into the link between this and child abuse. The reality is that women may have a variety of reasons for their behaviour. Reder et al (1993) in their overview of 35 Child abuse enquires highlighted that an ambivalence to or rejection of pregnancy and delayed antenatal care was an important risk factor for child abuse and neglect. Where guidance exists (see for example West Sussex policy[xv]) professionals are encouraged to explore the reason for this if an appointment is made very late for antenatal care (after 24 weeks of pregnancy).

3.18 One of the primary ambitions of the Healthy Child Programme is to ensure that all parents are well prepared for parenthood. Mother started to access antenatal care about 8 weeks before she and Father became parents. They had not attended any parent craft classes, and had not actually prepared themselves psychologically for this role.

3.19 Delayed antenatal booking also presents medical and service challenges, leaving only a short window for the relevant health checks to be undertaken, and arrangements for the birth to be made. This case has represents the paradox whereby women who delay booking for antenatal care – for whom there may be increased psychological and other risk factors – are *less* likely to have their emotional and psychological needs investigated and responded to, due to the urgency of their medical needs.

3.20 It is essential that the meaning of delayed first presentation/late booking is assessed, and its meaning explored in all cases, regardless of whether there are other obvious risk factors.

How did the issue manifest in this case?

3.21 Child A's Mother delayed first presentation/late booking for both her pregnancies. She said on both occasions that she did not know she was pregnant because she had irregular periods, and so would use a pregnancy test to see if she was pregnant. On both occasions she gave a different story to different professionals, and there were clear inconsistencies. One Midwife noted that in her second pregnancy, it was obvious that she was pregnant, which called into question her assertion that she had not known. This was not addressed, and did not lead to any questions or analysis about the meaning of the delayed first presentation/late booking.

3.22 There is no evidence that Mother was asked more questions about the delayed first presentation/late booking, or that the issue of a concealed pregnancy, ambivalence about this baby or being a parent were considered. The issue of the lack of preparation for this new role was not covered, and it remains unclear what the meaning of this was for the care or wellbeing of Child A.

How do we know it is an underlying issue?

3.23 Mother delayed booked for both her pregnancies and received a similar response each time. The meaning of her delayed first presentation/late booking was not assessed.

How prevalent and widespread is the issue?

3.24 There is no precise information about how many women delay booking for their pregnancies, although it appears nationally to be a small percentage of births. At a local level it was reported by the Clinical Business Unit Manager for Women and Children's services, Bedford Hospital that it was common to have a number of delayed bookers in the maternity unit every month. It is however a significant issue which needs further discussion.

Finding 2: There is insufficient knowledge and understanding about the potential consequences of delayed first presentation/late booking on the welfare and mental health of the family.

Delayed first presentation/late booking is recognised as a risk factor for babies, and as a potential indicator of emotional/psychological issues in women and needs careful discussion and thought. The recent research review completed by the NSPCC highlights particularly the vulnerability of young babies[xvi], and the recent Ofsted review of Serious Case Reviews noted that a significant number were held for babies under 1 year old. There are significant potential risks for babies if we do not balance the need for medical issues with psychosocial ones where women delaying booking for antenatal care.

Questions for the BBSCB

Does the Board recognise late booking in any context as is an important issue?

Has the Board done any previous work on exploring this issue within the multiagency children's workforce?

How can the Board be assured that this issue will be addressed and lessons shared?

Is there a clear pathway for professionals to follow regarding delayed first presentation/ late booking?

If the Board decides to take action in this area, what measures will it put in place to test whether it has been successful?

Finding 3: The message about the importance of routine enquiries to be made about domestic abuse in the pre and post natal period may have got lost where there are no other obvious risk factors.

3.25 Domestic abuse has a profound impact on women, men and children. International research suggests 4–8 per cent of all pregnant women are victims of domestic abuse[xvii]. One study suggested rates of domestic abuse (severe to moderate violence) increase after birth compared to the antenatal period[xviii]. The same study found that 40–50 per cent of women who experienced physical abuse also experienced sexual assault. The Psychiatric morbidity survey estimates 33,000 babies under 1 in England, equivalent to around 39,000 in the UK, are living in a family where there is domestic abuse. There is now increased understanding that the consequences of heightened maternal stress during pregnancy as a result of domestic abuse extend to the foetus – and later to the newborn infant as young as one year old can experience trauma symptoms as a result of witnessing domestic abuse. There are significant long term negative outcomes for a child living with domestic abuse and early identification and the provision of safe and caring opportunities for disclosure are an important part of a universal response.

3.26 The Healthy Child Programme makes it clear that all parents should routinely be offered the opportunity to discuss domestic abuse as part of a broader strategy of a preventative health programme for children. This routine enquiry, alongside other health issues, is important because domestic abuse affects women and men from all sections of society, and is often an issue where no other obvious risks exist.

How did the issue manifest in this case?

3.27 Mother made allegations to the Police that Father was domestically abusive soon after Child A was born. These were addressed by the Police, and referrals were made to Children's Social Care, and these were recorded, and led to no further action.

3.28 This information was not known to the antenatal or postnatal professionals that Mother came into contact with, and there is no evidence that she was asked about domestic abuse by them. Father also alleged that Mother had been domestically abusive to him. This was not known by professionals until much later, but there is no evidence that he was asked about domestic abuse.

3.29 Mother told the GP in January 2012, when Child A was 4 months old, that Father had been threatening to her. There is no evidence that the GP discussed the impact of this on Child A or considered talking to another professional, such as the Health Visitor, to see if further support was needed. Given the potential impact of domestic abuse on the emotional wellbeing of an infant, and parent - child attachments, this was a missed opportunity. It remains unclear what the impact of these early conflicts were on Child A's emotional wellbeing.

How do we know it is an underlying issue?

3.30 The Case Group expressed surprise that Mother had not been asked about domestic abuse, because their sense was that this was well embedded in practice. However, they recognised that they are often influenced by the circumstances of parents. The Review Team and Case Group concluded that asking about domestic

abuse was well embedded in practice where there were clear risk factors, but that with parents who present as coping and no obvious concerns, it was less so.

How prevalent and widespread is the issue?

3.31 Current research suggests that 1 in 3 women and 1 in 7 men will experience domestic abuse in their lifetime. This risk is significantly heightened during pregnancy and in the early days of parenthood. Research also makes clear that domestic abuse affects people from all sections of society, and is often hidden where parents live in reasonable economic and social circumstances. It is therefore a significant issue in the context of pre-and postnatal care.

Finding 3: The message about the importance of routine enquires to be made about domestic abuse in the pre and postnatal period may have got lost where there are no other obvious risk factors.

Domestic abuse is a serious issue during pregnancy which can have a profound negative impact on women and the health and wellbeing of the unborn baby. It can affect the development of positive parent-child relationships, which are the cornerstone of children's wellbeing. There is also clear evidence that domestic abuse has profound long term negative consequences for children, with their health, mental health, success at school and ability to build good relationships with others. It is essential that domestic abuse is detected early on and that those affected are provided with an active and sensitive response.

Questions for the BBSCB

Is the Board confident that all antenatal and postnatal professionals are aware of the importance of the sensitive and routine asking of all men and women about domestic abuse?

Are the Board aware of whether professionals feel equipped to ask these questions and how to respond appropriately?

What strategies can the Board employ to address this issue?

If the Board decides to take action in this area, what measures will it put in place to test whether it has been successful?

Finding 4: Preconceived ideas about fathers as either "good" or "bad" influences potentially whether they are involved in assessments regarding their children. This means that important information about risks may be lost.

3.32 Children Act 1989 and the Human Rights Act 1998 makes clear that fathers have a right to be centrally involved in decision making, planning and services regarding their children. Research suggest that fathers have a significant role to play in children's lives and as part of his review of child protection systems Laming said "*Particular mention should be made of the part to be played by fathers, not least as good role models*".

3.33 Research[xix] and Serious Case Reviews[xx] have shown that fathers and father figures are often invisible to professionals, and are not always successfully included in work regarding their children.

3.34 There is evidence from research that professional perceptions of men in child protection work appear to be "*as a threat, as no use, as irrelevant or absent*"[xxi]. This 'fixed thinking', means that men were perceived in polarised ways as either primarily

'good' men (good dads) or 'bad' men (bad dads). The research showed that beliefs linked directly to whether fathers were thought of by professionals as reliable or unreliable, trustworthy or untrustworthy. When professionals adopted this restricted way of thinking they could discount a 'bad' dad's concern about the welfare of children (Brandon et al 2009[xxii]).

3.35 Ferguson and Hogan (2004)[xxiii] found that stories about fathers 'float around the system'. In their study of fathers', men's identities were sometimes constructed by professionals in collaboration with family members, and fathers were often labelled as dangerous without the professional having had any direct contact with them. Based upon this fathers were often excluded from decision making. The use of negative stories about fathers has also been found by Scourfield [xxiv](2003) to influence whether they were included in assessment, plans and decision making.

3.36 This "fixed" thinking runs contrary to the ambitions of the Governments "Fathers Matter campaign" which was launched in 2008, alongside a best practice framework to help agencies and LSCBs develop effective practice[xxv].

How did it manifest in this case?

3.37 In March 2012 Child A's Father initiated a Private Law application regarding contact and a shared Residence Order for Child A. Early in the process both parents made allegations about the other. Mother said that Father had used cocaine in the past, and she was concerned that this remained as an issue which might impact on his care of Child A. This allegation influenced thinking about the contact arrangements, and it was felt necessary to ask Paternal Grandmother to be present. Father took a drug test, which proved negative, and no other evidence about drug taking emerged.

3.38 Father made counter allegations that Mother had significant problems with alcohol and she took a liver function test which provided negative.

3.39 Mother shared during the first hearing for the shared Residence Order that Father had been violent to her; in fact there was never any evidence of this. She had reported a number of incidents of harassment and that Father had damaged her car. This was subsequently shown to be a false allegation, and Mother was subsequently arrested, but not charged, for perjury.

3.40 Father provided a large amount of information to the first hearing, which included allegations of Mother's violence and aggressions, her alcohol misuse, self harm and he produced vast quantities of texts from her to him, and photos of a pornographic nature, which he found on his computer. These were significant concerns which had the potential to have an impact on Mother's ability to provide safe care to Child A. These concerns were dismissed in court, and were seen as evidence of Father's controlling behaviour in the context of domestic abuse. This meant that these allegations were never assessed, and the implication for the parenting of Child A never established. The information was never shared outside of the court arena, and Father's concerns were never acknowledged.

3.41 In March 2013 Father was not included in the assessment that took place regarding the half-sibling but which also related to his child. This assessment included information about him being domestically abusive, and that Mother had established a pattern of appropriate contact arrangements, because she was aware of the importance of the relationship between Father and Child A. This was far from the truth, and an opportunity to provide Father with a voice was lost.

How do we know it is an underlying issue?

3.42 The Case Group recognised that fathers are often marginalised, particularly when there are concerns about domestic abuse. Research and Serious Case Reviews support that this is an underlying issue nationally. The Case Group recognised that fixed thinking about violent men influenced the extent to which they should and could be involved in decision making. It has not been possible to talk to those involved in the court process, or to establish the extent to which this is an underlying issue in private law applications locally.

How prevalent and widespread is the issue?

3.43 Nationally, there is considerable evidence that fathers are marginalised from decision making about children, and court processes.

Finding 4: Preconceived ideas about fathers as either "good" or "bad" influences potentially whether they are involved in assessments regarding their children. This means that important information about risks may be lost.

Fathers are important to children, and it is critical they are given a voice. There have been a number of high profile Serious Case Reviews where fathers have tried to alert professionals to concerns about a mother's care of children and have been disregarded because of perceptions that they were unreliable (Hamza Khan, Baby Peter). It is imperative that fixed views about men do not get in the way of providing an individual response based on the needs of children.

Questions for the BBSCB

Does the Board agree this is an issue?

Does the Board have any information about the involvement of fathers in decision making from early intervention to safeguarding?

Is the Board aware of the Father Matters Initiative, and what it could offer in terms of addressing this issue?

If the Board decides to take action in this area, what measures will it put in place to test whether it has been successful?

Finding 5: Opportunities were missed to share information with health colleagues which would have allowed other professionals to undertake a more comprehensive assessment of the family's wellbeing and the couple's readiness for parenthood. If appropriate information is not shared with the multi-agency network this could lead to instances where there is an incomplete assessment of a child's wellbeing

3.44 The wellbeing of children depends on appropriate joint working between agencies and professionals that have different roles and expertise. Individual children and their families need support from health, education, early years, children's social care, the voluntary sector and other agencies.

3.45 GPs are an extremely important element of this network. They are well placed to recognise when a parent or other adult has problems that may affect their capacity as a parent or carer and is crucial that the optimum possible use is made of their skills and experience. Part of this is an informed approach to effective information

sharing which underpins integrated working and is a vital element of early intervention.

How did it manifest in this case?

3.46 Mother went to see her GP in June 2011 because she thought she was pregnant. This was confirmed, and she asked her GP to organise a termination. An appointment was made by the GP at a termination of pregnancy services clinic, where Mother was assessed as being 30 weeks pregnant. As a result of the late stage of pregnancy, the Mother subsequently returned to her GP and an antenatal referral was completed. The information about the termination request was not included in the referral. The termination request was viewed by the GP as an adult decision, and a personal one for the Mother involved. In this situation Mother and Father had made the decision to terminate the pregnancy, but the significant issue was that they were not able to do so, and this therefore also became about the needs and circumstances of the unborn child. In these situations, in line with the Healthy Child Programme it is essential that all health professionals There is no evidence that the GP assessed the potential psychological impact this may have had on the Mother and Father, or discussed with the Mother, her relationship, or attitudes to the baby who at this stage could be unwanted. This was a significant gap and meant that the Midwife who saw her next did not know that the baby was potentially unwanted.

3.47 There is no evidence that the GP discussed the reason for the termination with Mother, they did not know that that Mother and Father were about to separate because of the volatility of their relationship and that they had never planned to be parents. Research suggests that unwanted pregnancies are linked to potential physical and emotional harm as well as poor quality care/neglect[xxvi]. This was important information that should have been shared and would have contributed to a fuller picture of the family circumstances in which Child A lived.

3.48 Mother did not tell the Midwife that she had wanted to terminate the pregnancy, and instead she chose to say that she did not know she was pregnant, but when she discovered she was, she was delighted to be so. The Midwife could not consider the meaning of this change in story or consider why Mother chose not to discuss the planned termination, because she did not know about it. In fact this was the beginning of a pattern of Mother giving different stories to professionals about why she delayed first presentation/late booking for both pregnancies. If the information had been shared, this pattern might have been recognised and addressed.

3.49 Serious Case Reviews demonstrate that it is often only when information, which is seemingly unimportant, is brought together from a range of sources, does a holistic picture of a child's life emerge. This good information sharing is important for their future healthy development, as well as to keep them safe.

How do we know that it is an underlying issue and not something unique to this case?

3.50 The GPs who were seen as part of this review felt that terminations were a private matter for women, and they did not routinely share this information with others. In this case there was a second example where information about Mother's anxieties, and allegations of domestic abuse were not shared with any professionals, despite Child A being 4 months old at the time. The Case Group told the Review Team that this was not a quirk of this case, but that they had encountered previously problems regarding information about adults, which related to the needs of children, which GPs in other circumstances had not shared with them. Research suggests this is a

widespread problem, and national inquires such as Victoria Climbie[xxvii] highlighted the need for GPs to take a child centred approach to information sharing.

How common and widespread is this?

3.51 There is no available information locally about this issue, and no work has been done to establish how widespread it is. However, the Review Team and Case Group attested to this being an important issue.

Finding 5: Opportunities were missed to share information with health colleagues which would have allowed other professionals to undertake a more comprehensive assessment of the family's wellbeing and the couple's readiness for parenthood. If appropriate information is not shared with the multi-agency network this could lead to instances where there is an incomplete assessment of a child's wellbeing

Information sharing across the multi-agency network is essential to ensure the wellbeing and protection of children. Serious Case Reviews show us that when information shared from a range of sources can the overall meaning for the child be understood effectively, and true picture of a child's life emerge. It is essential that professionals do not make these decisions in isolation, because they have decided that it is not relevant or proportionate to share. This is particularly critical in the pre-birth period and the first year of life. Research suggests effectively assessing and meeting the needs of parents and children at this time has a long term positive benefit for children and their families. Research also suggests that the first year of life is when children are most likely to be harmed. It is essential that all relevant information is shared to enable professionals to make appropriate decisions about the necessary support.

Questions for the BBSCB

Are the Board aware that information sharing by GPs to the wider multiagency network is an issue of concern?

How will the Board establish this?

What are the strategies that the Board could employ to address this?

If the Board decides to take action in this area, what measures will it put in place to test whether it has been successful?

4 ADDITIONAL LEARNING

4.1 Alongside the Findings, there were three significant issues which emerged from this review which the Board need to be aware of.

Significant Issue 1: There is insufficient acknowledgement of the emotional impact of child deaths and subsequent Serious Case Review on professionals

4.2 The Case Group told the Review that they felt that the way in which they were informed about the death of Child A and the subsequent Serious Case Review was unsupportive, unconsidered and disjointed allowing professionals to come away from those discussions feeling upset and deskilled. Several members of the Case Group told us they heard this news of Child A's death when they had just experienced some personal loss. They said they were expected to simply carry on with their job, without sufficient of what had happened. There was the exception of the Midwifery staff who felt well supported by their manager.

4.3 The Biennial Review of Serious Case Reviews [xxviii]highlighted the impact of being involved in a Serious Case Review for Professionals who talked about feelings of failure, guilt or being made a scapegoat and the words 'upset', 'traumatic', 'devastating', 'under scrutiny' and 'vulnerable' were all used . Another recurring theme from the Biennial Review was the lack of support and supervision of practitioners involved in Serious Case Reviews and the need for an immediate support service. Practitioners feel 'out on a limb' and isolated. There can be a lack of knowledge and understanding of what will happen next in the review process, and a "period of uncertainty whilst awaiting outcomes; a step into the unknown".

"The length of time the review goes on, one is carrying anxiety for a length of time, especially if court case or media involvement". Member of staff.

Significant Issue 2: In this case the Father felt unable to share his concerns about Mother's parenting and impact on Child A because he was worried about being involved with "social services". Does the BBSCB consider that this is an issue beyond this case which requires action?

4.4 Serious Case Reviews have highlighted that observations and information from family, friends and neighbours may provide vital insights into the workings of families (Laming, 2003). They are a vital source of information. A review of families' perceptions of the child protection system (Wiffin 2010) suggest that there is a general lack of confidence in child protection processes, and a concern that to alert professionals to concerns is to open a family up to critical scrutiny where families have no control about the outcome.

4.5 There were a number of opportunities where the Father could have shared his concerns about Mother's alcohol misuse and violence, but he chose not to do so. He had contact with a number of health professionals, and presented a picture of a harmonious family when Child A was first born. He told the reviewers that this was because he did not want his child to be known to "social services". He agrees that he underestimated the impact of his silence, and when there were some concerns he was not then asked his view.

Significant Issue 3: Crimestoppers – Clarification on how internal mechanisms properly identify, utilise and share safeguarding intelligence raised via this mechanism.

4.6 In November 2011 Crimestoppers received information that Mother was drink driving in the local area, with a child in the car. All Crimestoppers intelligence reports go directly to the Police Central Intelligence Bureau (CIB) Intelligence group email list and can be picked up by any of the staff on the 24/7 CIB Intelligence desks. All submitted intelligence, regardless of its source is viewed by the CIB Operations team to ensure that all actionable intelligence is attended to appropriately. There are 3500 logs per month and a grading system is used to prioritise those items that merit greatest attention and which have the highest degree of credibility. The content of the report regarding Mother was sufficiently detailed to allow action to be taken and was passed to Traffic Policing for their attention and action. There does not appear to be a mechanism for ensuring that this information is shared with the Public Protection Unit. This was a serious allegation about the needs and circumstances of a child. Despite the high volume of information, there should be a mechanism for Crimestoppers intelligence reports to go to the appropriate place.

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[v] A beta-adrenoceptor blocking drug (often referred to as a beta-blocker) **Anxiety**: anxiety can cause physical symptoms such as a fast heartbeat and trembling. Propranolol slows the heart rate to relieve these symptoms. (However it does not relieve the emotional symptoms associated with anxiety, such as stress or fear, so these symptoms should be treated separately.)

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[xiv] The term authoritative practice is referred to in the most recent biennial review and specifically in the Baby Peter executive summary which describes the approach as challenging and confronting about parenting, setting clear targets with short timescales and discovering motivation and capacity to be a responsible parent

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[xxv] The Think Fathers campaign aims to bring about a sea-change in British culture, politics and public services, whereby fathers' significance in their children's lives is fully recognised and acted upon.

The campaign has three goals:

• To transform children's, family and health services, including maternity services, pre-schools/nurseries and schools into services which systematically engage with fathers and support father-child and parental relationships.
• To promote public understanding and debate about fatherhood and how we can all support fathers' positive involvement in their children's lives.

• To develop father-inclusive approaches at work – for example, flexible working and leave arrangements for men and women which take account of fathers' roles in bringing up children

http://www.fatherhoodinstitute.org/2009/about-the-think-fathers-campaign/

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