THE BRIDGE

child care development service

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Serious Case Review – Case of Baby A

Executive Summary

Commissioned by London Borough of Havering Local Safeguarding Children Board

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NCH

The Children's Charity

1. Introduction

1.1 This report is the Executive Summary of the Serious Case Review report into the involvement of agencies in the London Borough of Havering in the case of Baby A, who died at Oldchurch Hospital in the borough on 30 March 2006 aged 32 days old.

1.2 A Serious Case Review is required of professional agencies in circumstances described in Government guidance, Working Together to Safeguard and Promote the Welfare of Children (HMSO, 2006). In this case the Chair of the Havering Safeguarding Children Board made a decision to proceed with a Serious Case Review on 20 April 2006 further to consultation with partners on the Board. The basis of this decision was that Baby A died as a result of child abuse.

1.3 The brief circumstances of this tragic event were as follows. On 26 March 2006, A was cared for by Mr R, the former boyfriend of A's maternal Aunt and father of A's cousin C, aged 4 months old. Mr R had purchased tickets for Ms P and A's mother, Ms H to spend the day at a spa session in London and had driven them there.

1.4 Mr R called emergency services at approximately 2:00 pm that day and reported that A was having breathing difficulties. A was taken by ambulance to Oldchurch Hospital where he was stabilised and transferred to a paediatric ward. Hospital staff noticed bruising to A on his back, buttocks, left side and thigh and referred the case to Havering Children's Social Services.

1.5 Later on in the evening of 26 March 2006, A deteriorated. Further tests indicated injuries most likely consistent with being shaken and assaulted. A was transferred to the specialist children's unit at Addenbrookes Hospital in Cambridgeshire and was accompanied by his mother and his father Mr L.

1.6 Staff at Addenbrookes Hospital stated on the following day that A had suffered so much inter-cranial damage that he was beyond medical intervention. He was transferred back to Oldchurch Hospital on 29 March 2006 and died there in the early hours of 30 March 2006.

1.7 Mr R was subsequently arrested and charged with the murder of A. His trial is still outstanding at the time of conducting this review.

1.8 Ms H, Mr L, Ms P and Mr R had all been known to professional agencies in Havering throughout their adolescence and Ms P and Mr R had both spent periods in local authority care. As all the parents in this case were still young and had had such contacts, a decision was made to review whether there were lessons to learn from the historical service delivery as well as focussing on the involvement of agencies in the year prior to A's birth and death.

1.9 The specific terms of reference agreed for this Serious Case Review were:

- To look at the circumstances surrounding A's death and identify any predicting factors that may have alerted local agencies to work together to prevent A's death.

- To look at the supports available to A's young parents in the light of their own parenting experiences.

1.10 In line with national guidelines and the London Child Protection procedures, agencies involved provided individual agency reports and chronologies of involvement. These reports were then brought together in an independent overview report and composite chronology. The agencies producing reports in this case were:

- Addenbrookes Hospital NHS Trust
- London Borough of Havering Children's Services (Social Services)
- London Borough of Havering Children's Services (Education Services)
- Metropolitan Police Service
- Barking Havering and Redbridge Hospitals NHS Trust
- Havering Primary Care NHS Trust
- North East London Mental Health NHS Trust (NELMHT)
- London Probation Service

1.11 A genogram of the family members is provided as Appendix One to this report.

1.12 It is important to stress that the purpose of a Serious Case Review is not to investigate why individuals behaved in the ways they did nor is it to investigate the death of Baby A. The purpose is to explore the actions of agencies with family members and to identify whether the case gives rise to lessons to be learned to improve outcomes for other children in other cases.

2. Key Themes

2.1 This review has considered the involvement of agencies with both the young adults as children and the involvement of agencies with these young adults and their children, and with them in the months leading up to the incident leading to the death of Baby A.

2.2 The review is able to conclude that there were no agencies, which could have predicted that A would be harmed or killed by anyone in contact with him.

2.3 The pattern of service delivery to the four young adults as teenagers was one of sporadic involvement, missed appointments and limited engagement on the whole. Only Mr R achieved significant results at GCSE level and Ms H and Ms P were both subject to Statements of Special Educational Needs. There was clear evidence in records of all four adults having lived difficult childhoods in families where there were issues of parental separation and disharmony and where boundaries were problematic for children's behaviour. There were also indicators on record about domestic violence, alcohol abuse and physical and sexual abuse of some of these young people as they grew up.

2.4 In the year leading up to A's birth and death, some support to Ms H and Ms P was offered by the Children's Social Services Leaving Care Service. This service also saw both Mr L and Mr R on occasions as they accompanied the young women to the support group. The support worker at the Havering Young Parents Support Project made particular efforts to engage with Ms H, although often to little avail. Mr L was in infrequent contact with adult mental health services around his agitation and anxiety and both Ms H and Ms P were prescribed anti-depressant medication. Ms H took an overdose of tablets in April 2005 further to a fight between her boyfriend and brother and was admitted to hospital and assessed by the duty psychiatrist. Mr R was convicted of theft from his employer in July 2005 and sentenced to 150 hours of unpaid work through a Community Punishment Order administered by the Probation service.

2.5 There continued to be episodes of violence affecting the lives of Mr L and Mr R and police were called, for instance, to fights involving each of them with their own fathers. Mr L was also the victim of an alleged assault in February 2006 by two other men, one of whom was Ms P's new boyfriend and the assault was thought by Mr L to have been occasioned by the perception of him making a comment about Ms P.

2.6 The birth of A was unremarkable although his mother had been admitted to hospital only a few days earlier with a grand mal epileptic seizure. A and his mother were discharged from hospital the following day and received regular and frequent follow-up from the midwifery service thereafter.

2.7 The themes for consideration in Havering about how best to deliver services arising from a review of this case are as follows:

- ***How best to deliver services to vulnerable young people and adults***

This question is at the heart of the Government's *Every Child Matters* initiative. In this case, professional assistance was often not wanted by young people who were clearly vulnerable on any set of measurements, but who did not wish to identify themselves as such. The challenge for agencies in Havering, as elsewhere, is to find a way of delivering services, which improve the life outcomes for children by engaging with hard-to-reach families.

- ***Managing offenders***

The London Probation service complied with its National Standards in administering Mr R's Community Punishment Order. However, this process was simply concerned with administration of punishment when in fact it might have been possible, in a different criminal justice system, to build a picture of Mr R. This would have relevance to other offenders who are parents or who are in regular close contact with children. The answer to this question will not lie in Havering alone but Havering agencies might usefully engage Government in discussion about this issue.

- ***Children's Social Services assessments***

The Leaving Care Service did not use the core assessment guidelines from the national framework for the Assessment of Children in Need and their Families (HMSO, 2000) and the support group services lacked clear individualised aims and objectives for Ms H and Ms P. Services were also not made available in the same way to the men involved with the children in this case, even though they were the fathers of children to be born to young women accepted as services users by the Leaving Care service.

- ***Use of child protection procedures***

The historical records provide evidence of likely significant harm in the cases of both Mr L and Mr R. Child protection procedures and the use, for instance, of a child protection conference were not adequately considered. This is of course related to decisions of 10 or so years ago and may or may not bear relevance to the picture of services and thresholds in Havering today.

- ***Planning for looked after children***

Mr R entered foster care with his sister in 1994. The backdrop of circumstances involved concerns that were clearly around child protection. Yet he was discharged to the care of his father in 1996 without any assessment of whether this picture had changed and against his own views and when his foster carers wished to keep him on a long–term basis. This decision was a poor one on the face of it and the view formed that the grounds for a care order were not met did not appear to be correct

with the benefit of hindsight. Whether this would have made any difference to outcomes for Mr R is unclear of course; it should be noted that he did go on to achieve well at school in his father's care.

- ***Inter-agency communication***

There was a lack of information sharing and discussion between council Leaving Care services and midwifery and health visiting services. This reflected the fact that no agency had specific concerns but this remains an issue given the known vulnerability of the families involved. There were also some delays to information sharing following A's admission to hospital in March 2006 although these did not impede the effective handling of the child protection investigation.

- ***Recording***

The case gives rise to agencies needing to check on the quality of recording of contacts with service users to ensure accurate records are maintained wherever possible.

- ***Case Review Process***

The Havering Safeguarding Children Board can make use of the process of this case review to extend the learning involved in conducting reviews of agency involvement.

2.8 The case review also demonstrated good practice. Some examples of good practice were as follows:

- The Ward Manager at Oldchurch Hospital clearly represented the views of nursing staff to the strategy meetings following A's admission to hospital in March 2006.
- The strategy meetings following A's admission took place in the hospital in order to promote the attendance of clinical and nursing staff at the hospital
- There was clear information sharing and analysis of information relating to the injuries to A once communication between agencies had been established.
- The police borough command officers and those from the specialist child abuse investigation team appeared to liaise and work together productively in this case.
- The support worker at the young parents' project showed a fierce determination to seek to engage Ms H in support services
- Agencies planned immediately upon A's death to seek to offer effective supports to his parents.

3. Recommendations

3.1 The recommendations of this Serious Case Review are:

1. The Havering LSCB should find out through research and experience how best to meet the needs of vulnerable young people and consider the approaches and skills which will be best suited to working effectively with young people who do not identify themselves as having a need.

2. The London Probation service should work with its national Probation Service colleagues and with Havering LSCB to develop recommendations for delivery of community punishment schemes in ways which seek to ensure greater offender profiling, especially when the offender is a parent or about to become a parent. These recommendations are likely to have to be made to the National Offender Management service.

3. Children's Social Services in Havering should develop clear criteria so that whenever a most vulnerable care leaver or other young person under the age of 21 years is about to become a parent then a full core assessment of need of the expected baby and parents is made

4. Children's Social Services in Havering should ensure where appropriate that Leaving Care services are made available to partners of care leavers and significant others, such as ex-partners who are parents of babies, as well as care leavers themselves.

5. The LSCB in Havering should review the extent to which it is satisfied with information sharing between the Children's Social Services Leaving Care Service and other agencies in respect of babies and young children of care leavers.

6. The LSCB in Havering should take steps to ensure that there are not other current cases of a similar nature to those relating to Mr L and Mr R as children when there was a failure to invoke multi-agency child protection procedures.

7. Children's Social Services in Havering should introduce a procedure to ensure that whenever children express a wish not to return to a birth parent from a care placement, there is senior level consideration of any plan that seeks to forge ahead with rehabilitation.

8. The Havering LSCB should provide, or commission, training in the writing of Serious Case Review individual management reports and chronologies.

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APPENDIX ONE BABY A: GENOGRAM