

SIGNIFICANT CASE REVIEW

EXECUTIVE SUMMARY



BABY A – SOUTH LANARKSHIRE CHILD PROTECTION COMMITTEE

Introduction

Baby A was the first born in a relationship between Miss B (mother) age 27 years and Mr. C (father) age 31 years. Baby A died late 2012 when five months old.

Following police inquiries, and some two years after the event, the child's father Mr. C was charged with the crime. Mr. C denied the accusation.

The precise cause of death was unknown at the time, but over the following three years a number of post mortem examinations took place which eventually revealed injuries considered to be non-accidental in nature.

Mr. C remained adamant of his innocence until his appearance at the High Court in Glasgow in 2016, when he pled guilty to the culpable homicide of Baby A. He was sentenced to seven years and three months imprisonment. His change of plea came as a surprise to all involved with the case.

From the time of birth until mid-2012, the child was seen by health staff – midwives, health visitors and the family GP for entirely routine child development assessments and immunisations. There were no pre-birth or post birth concerns noted. The family and child were not known or flagged to any other agency for any concerns.

The Significant Case Review

Following the death of Baby A, South Lanarkshire Child Protection Committee commissioned a Significant Case Review to be led by an independent reviewer. Due to the delay in the criminal proceedings this was not commenced until late 2016.

The purpose of the Review was to:

- a) Establish whether there were lessons to be learned from the case and to identify any good practice to be shared about the way in which agencies worked individually or collectively to safeguard Baby A and;
- b) Identify how lessons learned and good practice are to be acted upon and what is to be expected to change as a result.

Members of the immediate and extended family were invited to participate in the Review, but the invitation was declined.

Findings and Analysis of the Review

The primary findings of the Review established that:

- 1) In the chain of events leading up to the death of Baby A, there were some breakdowns in agency procedures. By their nature, the Reviewer thought it would have been highly speculative to suggest a different outcome may have occurred in the absence of these breakdowns.]
- 2) Key staff across agencies lacked knowledge and understanding in areas of age related, child development which, if known, should have raised questions on explanations given by the parents in relation to two events which happened within eight days of each other. Where questions were raised, these were not pursued as vigorously as they may have been.
- 3) Apart from the above, all other case indicators pointed to positive care for Baby A when decisions were made by staff on safety and wellbeing.

Significant Events

The parents of Baby A contacted NHS 24 following an incident where Baby A was said to have rolled off a stool and fell on a cat whilst being changed. The nurse adviser dealt with the consultation appropriately as per the 'script, algorithm' she was expected to follow, but did not realise that Baby A, was at a stage of development where they would not normally have been able to roll of their own will. As such, this was not noted, or questioned by the nurse adviser and not communicated as a matter of interest to the GP practice. Given this, no concern was raised in the electronic communication sent by the adviser to the duty GP who therefore

simply recorded the message as 'correspondence' on the practice IT system. This being so, the contact would not be seen as urgent and would not be immediately brought to the attention of the GP.

Eight days later, at a pre-arranged GP appointment with the mother and Baby A, the GP referred Baby A to Hospital to ascertain if there was any underlying medical cause for a petechial rash and a bruise. The GP was not aware of the earlier NHS24 contact. The GP had no concerns about the presenting symptoms as being a child protection related issue.

Baby A was seen in a children's ward a few hours later by a paediatric registrar who considered the child's injuries to be, 'unexplained' and inconsistent with the explanations given by the mother as possible cause. Following procedure, she contacted the local authority's Emergency Social Work Services (ESWS) to discuss her concerns. The ESWS in turn contacted the police. The police advised the ESWS that its IT system was down and that the family protection unit were busy with another case and unable to respond at that time.

Between them, social work and the paediatric registrar agreed to allow the parents and Baby A home with follow up being undertaken by social work. A visit to the family home took place immediately. Social work staff who attended were satisfied with the care situation and agreed follow up support arrangements with the parents. Support consisted of health visitor contacts and a visit for immunisation. There was no further contact by services until five weeks later when the father contacted the ambulance service reporting that Baby A was having breathing difficulties. Despite the speedy arrival of the paramedics, Baby A had died before their arrival.

Following the ESWS home visit, the case was recorded as a child care concern rather than one of child protection, which was the position initially. Findings and future intentions were timeously communicated to the paediatric registrar and police by the ESWS. The police advised they would have no further involvement in the case.

Internal Agency Reviews

Internal agency reviews by the police and social work which were conducted later, found that certain actions did not fully comply with procedural requirements in that:

- (a) The paediatric registrar's referral to the Emergency Social Work Services constituted a child protection referral and should have been treated as such throughout until signed off by a manager as stated in South Lanarkshire Council's Child Protection Procedures. In the absence of identified risk following the home visit, it was concluded being unnecessary to proceed under child protection procedures and the matter was recorded as a child care 'concern' without recourse to a manager.

- (b) The police review concluded that on receipt of a referral it was the responsibility of the Police Family Protection Unit to raise a child protection referral and conduct checks on all available systems in order to obtain as much relevant information as possible. The review found that this did not happen to the required standard and that the Force's Standard Operating Procedures for Child Protection had not been followed in full. Recommendations were made to address deficiencies
- (c) No internal agency review was conducted by NHS Lanarkshire.

Learning Points

Research is clear that infants under 6 months of age do not generally possess the motor skills that allow them to roll of their own will. They are also unable to injure themselves at that age. These points must be borne in mind by all staff when considering non-accidental injury in non-mobile infants under the age of 12 months.

The 'scripts, algorithm' from which nurse advisors work within NHS 24 are non-specific in relation to injuries sustained by infants under 12 months of age and their associated risks. Because of this staff are at risk of missing crucial signs that a child may have been subject of deliberate harm. This position requires remedy.

The system of notifications from NHS 24 to GP practices can, in particular circumstances, lead to important aspects of a patient's medical history being overlooked and not taken account of.

In decision making and responses to child protection concerns, all agencies should have baseline knowledge and understanding about the risks of non-accidental injury in infants and young children.

There are inherent risks in making assumptions on child protection matters because of familiarity with an individual.

Child protection guidelines for NHS Lanarkshire employees are potentially ambiguous and are open to differing interpretation. This is unhelpful to all concerned. Terms such as 'unexplained' and 'non-accidental' are synonymous with child protection concerns, but may not always be obvious to all practitioners. Guidance refers neither to non-accidental nor unexplained injury and relies on individuals interpreting what they are seeing as one or the other.

Health visitors do not have open access to the medical records of children they are responsible for. This limited access through the GP has potential to adversely influence fully informed decision making.

The impact on staff dealing with a child's death or abuse should not be underestimated. There should be support systems available to staff who experience such tragic events.

Good Practice

The Lead Reviewer had access to the recording of the NHS 24 nurse advisor's contact with Baby A's parents. Notwithstanding the analysis concerning this contact given earlier in this report, the Reviewer was impressed with the thoroughly professional and empathetic manner of the advisor during the consultation.

The Reviewer considered response to the summoning of the ambulance by Baby A's father to be worthy of note. The vehicle and paramedics were on site within 5 minutes of receiving the emergency call.

Despite the various issues that arose from agency interactions following the referral to the hospital, children's ward, the Reviewer is of the opinion that the comprehensive and speedy responses to the situation staff faced at that time and immediately after was commendable.

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