Sunderland Safeguarding Children Board

BABY A

SERIOUS CASE REVIEW REPORT

In order to preserve the anonymity the author has:

- Used initials to represent people
- Avoided the exact use of dates

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Anonymisation Key

Designation	**Referred to as:**
Subject Child	Baby A
Mother of subject child	MA
Father of subject child	FA
Sibling 1	1st child of MA and FA
Sibling 2	2nd child of MA and FA
Sibling 3	3rd child of MA and FA
Maternal Grandparents	MGP
Health Visitor	HV

1. Introduction

1.1 This Serious Case Review (SCR) concerns a baby who died aged 20 days old following an assault by the family pet dog. Baby A was in the care of the father (FA) when the mother (MA) returned to the family home in the early hours of the morning following a family funeral to find the baby seriously injured. Baby A was taken to hospital by ambulance but tragically died from the severity of the injuries a short while later.

1.2 The circumstances in which the incident occurred have been subject to police investigation and FA was initially charged with Neglecting a Child so as to Cause Unnecessary Injury contrary to Sec.1 of the Children and Young Person's Act 1933, as well as being a person in charge of a dog dangerously out of control, causing injury resulting in death contrary to Sec.3 of the Dangerous Dogs Act 1991. FA was convicted of the second offence with the first offence laying on file. Subsequent investigation and assessment established that FA had a longstanding problem with alcohol and substance abuse and was under the influence of one or both whilst he had care of Baby A on the night of the incident. FA was asleep when MA returned home to find Baby A needing urgent medical attention. FA had stated that he was asleep while the attack occurred.

1.3 Baby A was the youngest of four children born over a period of eight years. MA and FA had been a couple for approximately ten years since early adulthood. Following the death of Baby A, it became apparent that the eldest child of the family stayed predominantly with the maternal grandparents (MGP) although this was not previously clear to universal services.

1.4 The family, apart from one incident referred to later in this report, were not known to Children's Social Care. The children were in receipt of universal

education and health services which revealed no additional safeguarding concerns. Following the death of Baby A however, the children of the family were subject to public law proceedings because of significant concerns about the circumstances within which the incident occurred coupled with the parent's response to initial investigations.

2. Decision Making Process and Methodology

2.1 The determination as to whether a Serious Case Review was indicated was considered by the Learning and Improvement in Practice Scoping Meeting, who made a recommendation that the criteria was met for a serious case review and the SSCB Chair at the time agreed with this recommendation.

2.2 The Serious Case Review commenced in October 2016. The Review was overseen by a Review Panel of senior officers from participating agencies. An independent reviewer was appointed to facilitate the progress of the Review and write an overview report.

2.3 It was agreed that this Review would be conducted taking an appreciative enquiry approach given the low profile of the family to multi-agency services. Each agency involved with Baby A provided a detailed chronology of key contacts and activities in order to establish who did what and when.

2.4 The independent reviewer along with the SSCB Business Manager met with key practitioners who had contact with the family in order to get a better understanding of their knowledge of the family as well as their reflections about the emerging issues from the review. Inevitably, given the limited knowledge of this family, the meeting had a strong focus on universal health services. It was particularly helpful that this meeting was attended by representatives of the separate GP practices for MA and the children, and FA.

Additionally, the independent reviewer had a discussion with a representative from the sibling children's school.

2.5 Criminal proceedings were instigated against FA following Baby A's death and FA was sentenced to 21 months custodial sentence in September 2017 for an offence of being in charge of a dangerous dog. The inquest into the death of Baby A was held in December 2017 and HM Coroner recorded that the baby had died of torso injuries. Recording a narrative verdict HM Coroner concluded that Baby A "was a vulnerable infant entirely dependent on the adults in his life to protect him from significant harm, provide care and a safe environment. There was a gross failure to provide this in the early hours of 20 June 2015 resulting in Baby A's death".

2.6 The Review Panel discussed the need to talk to both MA and FA. Taking on board advice from the police, this was however not possible until the criminal trial was concluded. MA and FA both subsequently declined to be part of the serious case review. In addition the Review Panel did not seek the views of the surviving children due to their distress regarding their sibling's death.

2.7 The Review Panel also considered the views of the older children in the family and whether it was appropriate to involve them in this Review. The Panel was mindful of two particular issues in reaching a decision; firstly, that the children had been subject to protracted public law proceedings which had created uncertainty and anxiety. Secondly, two of the children were asleep in the house while the attack occurred and were highly traumatised by the incident and subsequent events. Given that the children had never been subject to any interagency plan, it was agreed that the children's space for healing was more important for them than what they could contribute to a multi-agency review.

3. Scope and Terms of Reference

3.1 The chronology of key contacts took into account the whole family history. Each agency provided an evaluation of practice standards against key aspects of practice.

3.2 The Review Panel agreed that the following key lines of enquiry should be covered through the Review:

- explore how well the single and multi-agency safeguarding systems worked in identifying and responding to the needs of Baby A;
- determine the vulnerability of Baby A and how well potential risks could reasonably have been foreseen;
- building on learning from previous SCRs, to examine the challenges of working effectively with parents with problematic drug and alcohol use;
- consider whether professional judgement was supported by evidence, research and models of good practice;
- identify any safeguarding opportunities in systems which may enhance the safety of children facing similar risks.

4. Overview of what agencies knew about the family

4.1 This Review has considered a chronology which covers the history of family life from the birth of the first child. For the most part the information is unremarkable, however prior to the birth of Baby A there are some areas of information that are worthy of comment. The police information indicates that FA has a longstanding association with cannabis, and a criminal history which includes offences of possession and public protection. The offending behaviour is not continuous, and not repeated beyond 2010, nevertheless it does indicate a pattern of anti-social behaviours stemming from substance misuse. The records also suggest that illegal drug activity may not have been

confined to FA, noting that police intelligence in this respect related to MA too although no charges have ever been made. Significantly, there is no information known to any agency to indicate that FA misused alcohol.

4.2 The health records show that the family used health services in a way that the health professionals confirmed was much the same way as other families in the area where they lived. There were no indications that the family needed additional help. The children were taken for urgent medical appointments as necessary by the mother, both to the GP and on occasion to hospital. The chronology tells the story of a mother who is attentive to the immediate health needs of her children however there were a large number of health appointments with several instances of delayed follow up by the parents. Missed appointments were robustly followed up by health visitors which resulted in the children attending outstanding appointments. It is clear that MA was the parent responsible for the children's health and communication with the health visitor; if she wasn't available when the health visitor called, FA would redirect the health visitor to where she could be found or ask for a call back. MA was always co-operative with health visitors and responded to their prompts with regard to follow up health appointments. In addition to the health visitor, a nursery nurse from the health visiting team was in regular contact with MA offering support and guidance to manage medical appointments and the children's development.

4.3 The primary school considered MA to be a very engaged parent who was supportive to the children and wider school life. The professionals were of the opinion that the children were loved and cared for and had never had any cause to be concerned for their welfare. It should be noted that the primary school has invested significant and specific resources into safeguarding children, and would have been well placed to both identify and address any issues of concern.

4.4 There was one occasion when the family was referred to Children's Social Care two years prior to the birth of Baby A. This related to the then youngest child of the family S1. MA was observed by medical staff to hit S1 whilst in a hospital waiting area, telling S1 to 'get here or I will hit you' prior to swinging S1 into a pushchair and hitting the child in the stomach. The chronology shows that this occurred on the day that S2 was being discharged after a night in hospital. The hospital made a referral to Children's Social Care in accordance with the local safeguarding children procedures. This was not responded to in accordance with safeguarding procedures. Given what was witnessed was considered to be an assault, it was surprising that no strategy meeting was convened, there was communication between Children's Social Care and the police which agreed that Children's Social Care would report back to the police if there was evidence of assault. It should be noted that three health professionals had witnessed the reported assault including the Doctor who made the referral.

4.5 Children's Social Care responded to the duty under Section 47 Children Act 1989, by completing a single agency Initial Assessment when a joint investigation was necessitated. The assessment was poorly conducted and superficial; it relied solely on self-reported information by MA and disregarded the fact that the assault was witnessed as having taken place. The absence of a strategy meeting resulted in no police information being accessed which would have revealed FA's history of anti-social offending and substance misuse and police intelligence in relation to concerns about MA and illegal substances. The matter was closed by Children's Social Care, with the health visitor recording that the social worker had stated that the incident was a 'one off' incident when MA was stressed. FA was never spoken with during this assessment.

4.6 In the two years between the Initial Assessment and the fatal incident, the children attended school and nursery without concern being expressed by any heath or education professionals. Close scrutiny of agency records have revealed that no indicators of concern were overlooked.

4.7 MA booked in for midwifery services in respect of Baby A eleven weeks into the pregnancy. The midwife completed an Antenatal Vulnerability Assessment. MA attended all scans but did not attend the consultant appointment on three occasions. A midwifery review at 22 weeks and again at 25 weeks identified no problems.

4.8 At 26 weeks, MA was seen by the health visitor for an ante natal appointment and developmental check for S3. The visit noted the following:

- that S3 was ready for school: however, it was noted that MA believed the child was controlling toileting disruptively
- that the impact of parenting four children was discussed, further support was offered but declined by MA
- that there were no concerns about the home and that a specific discussion took place about the appropriate safety measures in relation to supervision of children and the family dog
- that FA smoked ten cigarettes daily and drank eight cans of alcohol per week
- the risks related to sudden infant death syndrome were discussed
- that the possibility of domestic abuse was not explored because FA was upstairs in the house
- that MA felt supported by FA and extended family, also that a close family member was terminally ill

4.9 MA continued to access regular ante natal care and labour was induced in hospital at 40 weeks. Baby A was born safe and well. MA and Baby A were discharged home the same day.

4.10 Following discharge, Baby A and MA were seen on five occasions by midwifery, at day 1, 2, 5 and 9 at home and day 16 in clinic. Baby A commenced a course of anti-biotics as a precaution due to S3's physical illness, and was a little jaundiced in the first week. On day 9, Baby A had a rash and MA was advised to take the baby for paediatric oversight immediately. MA followed this advice, and the baby was prescribed cream with no follow up requested unless symptoms continued or worsened.

4.11 When Baby A was 4 days old, the health visitor received a notification of the birth. On day 9, the midwife contacted the health visitor to enquire about the primary visit. The health visitor arranged a home visit with MA by telephone for three days later. On day 12 MA was not home to receive the visit. The health visitor left a card with a further appointment for five days later, but MA was not at home to receive the visit. The health visitor left a further appointment card to visit the following day and contacted the midwifery service who advised that MA and Baby A had been seen the previous day in clinic. The following day, MA contacted the health visitor to request the visit was changed as she needed to be with a close relative who was nearing the end of life. The health visitor agreed to conduct the visit the following week.

4.12 There were no more professional contacts with the family until the fatal incident two days later.

5. Analysis of Practice

5.1 The police investigation which followed in relation to the incident revealed a family who were exposed to risk associated with alcohol and drugs which was not known to any other agency prior to the fatal incident. For this reason, and in order to gain a complete picture of how this family was known to agencies with safeguarding responsibilities, the agencies contributing to this review were asked to consider their records across the ten year span of family life.

5.2 Whilst it is apparent that the family did in the past have some associations with drug culture, there is no information to suggest that this was on-going, that within the lifespan of Baby A or indeed for many years prior to that. What appears to be more significant is FA's longstanding misuse of alcohol and the impact this had on the risk to Baby A. MA had reported to the health visitor that she was well supported by FA, but the reality of his alcohol misuse was never shared by her.

5.3 The health visiting assessment prior to the birth of Baby A was thorough. The health visitor asked pertinent questions to gain a comprehensive picture of family life which included the two aspects of risks significant to the death of Baby A, namely alcohol consumption and the presence of a family pet dog. The dog was a Lakeland Cross Terrier; this dog does not fall into the category of dogs defined as dangerous in the Dangerous Dog Act 1991 or any other published lists of dogs known to have a greater propensity to cause injuries to adults or children. Research on the breed gives no indication that this breed of dog is unsuitable as a family pet; it is clear however, that the dog, originally bred for hunting, needs high levels of activity and stimulation. Research on the breed gives a warning that the dogs can be possessive of their toys and food, they have strong survival instincts which mean that they should not be trusted around small children who do not understand boundaries. The health

visitor was knowledgeable about the breed and discussed the need to acquaint the dog with the baby in some detail with MA.

5.4 What happened in the house on that night, and the context of this, was dealt with through criminal proceedings, which resulted in FA being jailed for 21 months for being in charge of a dangerous dog, and a child neglect charge was ordered to lie on file. The incident occurred in the early hours of the morning after MA had attended the funeral of a close relative. Information from the school and health visiting records would suggest that MA would normally have responsibility for the children. FA was not known to the school although MA was in constant contact and a regular attender at school events, giving time to support trips and activities.

5.5 It is not disputed that FA drank substantially in the hours leading up to the incident. For the purposes of learning from this review, the review panel was keen to involve both MA and FA to establish their understanding of the impact of alcohol and its effects in their family life. Through reviewing information available from the criminal investigation and legal proceedings in relation to the older children, it is clear that FA drank a high quantity of alcohol on a regular basis and in all likelihood had a dependency on alcohol.

5.6 The NSPCC briefing on Parents who Misuse Substances: Learning from Serious Case Reviews, published 2013 provides an analysis of findings from serious case reviews in relation to drugs and alcohol. It reminds professionals that children with parents operating under the influence of drugs or alcohol face significant risk in terms of co-sleeping and accidents and incidents caused through a lack of supervision. In addition, it warns professionals to treat with caution the parent's account of how much and how often they drink or take drugs.

5.7 The ante-natal assessment undertaken by the health visitor demonstrated a good level of alertness to potential risks, and addressed a range of factors including MA's health and support network, the impact of a fourth child, the family dog, and the use of alcohol. FA was reported to drink eight cans of alcohol per week. There was a range of positive factors present in this family, including the availability of two parents, a history of parenting three other children without difficulty and a willingness to engage albeit prompted at times to do so.

5.8 Given what is known now, there are two specific areas of learning that can be taken from this Review. Firstly, and not uncommonly, the need to work with families with an expectation that relevant men will be directly included in assessment activity and communications with professionals. Throughout all contacts with this family, FA is somewhat invisible to agencies whilst also being reported by MA to be a supportive parent. Secondly, the need to explore reported alcohol consumption at a deeper level. 'Eight cans a week' does not translate into an assessment as to whether recommended alcohol consumption limits are being adhered to as this would depend on the strength of the alcohol and the pattern of drinking. With the knowledge of hindsight, it is highly likely that this reported level of alcohol consumption was an underestimation.

5.9 Alcohol dependence is often described as a family disease, because all family members are affected by one person's alcohol dependence. Commonly families develop coping mechanisms in unhealthy and non-productive ways, which over time undermine the resilience of the whole family. On the night of the incident, MA gave FA money to purchase alcohol for them both, 6-8 cans of alcohol for FA (the number is disputed) and four cans for MA. FA was joined by a friend who said they shared a bottle of wine before ordering a cab driver to bring a further 8 cans of alcohol. FA refused to answer questions or

to undergo testing when he was arrested following the death of Baby A, but he had consumed a minimum of eight cans of alcohol. FA's assertion that this was not unreasonable to his circumstances of caring for a new born infant underlines the fact that his self-assessment of his own alcohol use had become unsafe.

5.10 Given the limited facts available to this Review, it is difficult to offer analysis about what prevented FA's high level of drinking being identified as a risk factor, but it is apparent that his level of drinking was underreported by MA to the health visitor. There are a number of possible explanations for this, most obviously either MA had an enabling co-dependent relationship with FA, or that she did not recognise his behaviour as dependent because her own interpretation was affected by the prevailing family and community culture and attitudes towards alcohol. A further explanation could be that for many families, dependent drinking is something that is kept secret from the outside world through a sense of shame and embarrassment, or the desire to protect the reputation of the drinker. FA never presented with an alcohol problem to the GP prior to the incident, and there is no information to suggest that MA ever discussed such a concern with any professional.

5.11 The Initial Assessment completed by Children's Social Care focussed narrowly on the circumstances whereby MA was observed to hit S1. The absence of a Section 47 investigation in 2013 and the interagency issues this raises with regard to safeguarding procedures and challenge is a matter previously identified through the Ofsted inspection in 2015. The inspection found significant deterioration in services since the prior inspection in 2012, identifying that the threshold for access to services was not sufficiently understood or applied by partner agencies in the multi-agency safeguarding hub. The Initial Assessment concluded that the incident with Sibling 1 occurred in the context of MA having a particularly stressful period, with one

child being discharged from hospital whilst S1 was proving hard to manage in the hospital setting. The Initial Assessment was closed on the basis that MA had an available support network which formed a preventative factor; the assessment did not include any direct contact with FA and therefore relied heavily on the self-reported information of MA.

5.12 Whilst in no way suggesting a more robust approach would have prevented subsequent events in this family, it is however reasonable to consider that a strategy meeting would have provided wider agency access to historical police information that may have revealed that MA and FA were coping with greater and more longstanding difficulties than was apparent at that time. Although speculative, given the parents' responses to sharing information truthfully after the death of Baby A, it is also reasonable to believe that neither MA nor FA would have offered information that exposed an accurate picture of the presence of drugs and alcohol in their family life.

5.13 The information available to this Review is very limited, but it does provide a picture of an attentive mother who supported all of her children's needs with low level support from universal services. It also indicates that MA took responsibility for all formal liaisons with the children, and was the only parent offering encouragement and taking pleasure from their educational experiences. On the day of the incident, MA had suffered the loss of a very close relative just three weeks after giving birth to Baby A, it may well have been an unusual occurrence for FA to have sole care of all of the children. The risk from the combination of a baby, a dog, and a lack of supervision resulted in a fatality. The family life had continued safely until the element of lack of supervision entered the equation, and this was the consequence of an unrecognised risk from FA's dependent drinking.

5.14 The risk was unrecognised to professionals because it was unknown. In this instance, the health visitor identified and addressed any potential risks with MA as part of a standard health visiting approach but without MA disclosing of the risk factor of FA's drinking, this outcome could not have been further preventable by professionals.

6. Learning from the Review

6.1 The significant learning arising from this review is the stark reminder that many families carry vulnerabilities and pressures not known to professional agencies which may increase risk. It is therefore vitally important to ask the right questions whilst impressing upon families the consequences of not addressing issues that may become a risk to their children.

6.2 In this instance, the death of Baby A cannot be attributed to one risk factor, but to a combination of alcohol misuse and the resultant impairment of judgement, the presence of a dog with a vulnerable baby, and an unforeseen family crisis that meant usual family caring arrangements were adjusted. An unexpected crisis in the life of a family is often a time when otherwise managed vulnerabilities become exposed, and in this case, fatal risk developed at an unstoppable pace.

6.3 Ultimately, this Review tells us that professionals need to help families to think about unthinkable risks posed by family pets to children and demonstrates the need to educate both parents about the risks of alcohol to the safe care of their children.

7. Recommendations

1. The SSCB will work with key stakeholders and partners, including Public Health, to deliver public awareness raising campaign around the potential risks to babies and children as a result of:
    - Parental use of alcohol which compromises their ability to safeguard their children
    - Dogs who are not properly supervised by their owners or caretakers

   This campaign will run during Child Safety Week which takes place in the week beginning 5th June 2018.

2. The SSCB will undertake a multi-agency audit in July 2018 to evaluate how effectively the learning from this Review and from the public awareness campaign has been embedded into frontline practice.

3. The SSCB will raise awareness of the need for taxi drivers to be vigilant and report concerns for children's welfare when transporting alcohol to adults who may be parents or carers. This will be undertaken through contributing to the annual safeguarding training for Sunderland licensed taxi drivers 2018-2019.

APPENDIX 1

IMPACT STATEMENT

Sunderland Safeguarding Children Board Impact Statement

What have we done and what difference has it made?

- The SSCB provided guidance on assessing the needs of babies and children when there is a dog in the home immediately following the death of the baby. This information has been shared across the partnership and is also available on the SSCB Website.

- The SSCB has also added a procedure to its sub regional procedure manual in respect of Dangerous Dogs and Safeguarding Children which was launched on 9th November 2017. The procedure also has the following supporting guidance:

    - The Blue Cross Be Safe with Dogs – Guidance for Families
    - The Dogs Trust : Staying safe with Dogs
    - Kennel Club's Safe and Sound Programme with Resources for Schools
    - National Animal Welfare Trust Advice Sheet/Free Webinar
    - Battersea Dogs and Cats Home – 7 minute animated film to keep children safe around animals

  The procedure and guidance highlight potential risks to all children when they live with and visit homes or venues with a dog regardless of the breed and aims to ensure families and professionals are aware of these risks and put plans in place to minimise the risks to all children in the home. The anticipated impact of introducing the guidance and procedures is to enable practitioners in conjunction with families to identify and minimise potential risks to children of all ages.

- The Board shared the final draft of the overview report with HM Coroner Sunderland to assist in the scoping of the inquest. The purpose of this was to share the findings of the enquiries undertaken and the action taken and planned by the SSCB as a result of this review.

- The Local Safeguarding Children Board (LSCB) functions in relation to child deaths are set out in Regulation 6 of the Local Safeguarding Children Boards Regulations 2006, made under section 14(2) of the Children Act 2004. The LSCB is responsible for:

a) collecting and analysing information about each death with a view to identifying –
   i. any case giving rise to the need for a Review mentioned in regulation 5(1)(e);
   ii. any matters of concern affecting the safety and welfare of children in the area of the authority;
   iii. any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

b) putting in place procedures for ensuring that there is a coordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

As this Review progressed updates and learning was provided to the Sunderland Local Child Death Review Panel (SLCDRP) and the South of Tyne and Wear Child Death Overview Panel (SoTW CDOP). The full overview report will be shared with both the SLCDRP and the SoTW CDOP in March 2018 with the purpose of ensuring that the findings are shared more widely and that they will inform local strategic planning. The purpose of this process is to reduce the number of preventable deaths.

- The SSCB Chair has had oversight of the newly Public Health commissioned 0-19 year[1] contract for Sunderland. This contract includes the requirement to ensure that all antenatal visits address:

  "m. Safe sleeping arrangements, including risk factors and preventative measures for Sudden Infant Death
  n. Assessment of home environment, including (though are not limited to):
  I. Environment where baby is planned to sleep
  II. Hazards within the home
  III. Presence of animals within the home"

  Sunderland Public Health has embedded the learning from this Review into the contract specification and the provider will be measured, among other things, on how it delivers on this learning. The SSCB Chair, on behalf of the SSCB, will continue to monitor the effectiveness of the contract at appropriate stages, starting in March 2018 through a meeting with the Director of Public Health.

[1] The 0-19 Public Health Service in Sunderland is an integrated service for expectant mothers, children, young people and families in Sunderland that offers interventions from the antenatal stage up to the age of 19.