Serious Case Review, Baby A

(Born January 2017, died August 2017)

Final report

Independent reviewer: Felicity Schofield

August 2020

1. Introduction

1.1 The subject of this Serious Case Review (SCR) is Baby A, a baby girl of Asian origin, who died as a result of a head injury in August 2017, aged 7 months. Baby A had a twin brother who was not injured and is now living with his paternal family.

1.2. Following her death, a number of other injuries were found on Baby A, all of which were deemed to have been non-accidental. The earliest of these was concluded to have occurred approximately four to six weeks before her death. The other injuries were found to have occurred in the days leading up to her death.

1.3 There was nothing about this family that might suggest that their daughter would be deliberately harmed. The parents were not previously known to any safeguarding service and no safeguarding concerns had come to light during the ante-natal period, whilst Baby A was in hospital or whilst she was living at home.

1.4 Baby A was born prematurely and with significant health problems which required her to remain in hospital for the first four months of her life. Once she had been discharged from hospital, she continued to require some nursing care and was fed through a naso-gastric tube.

1.5 This Review covers the time period from June 2016, when the mother first became known to ante-natal services, through to August 2017 when Baby A's brother was removed from the care of his parents.

1.6 The Review has sought to describe and analyse the professional activity in the weeks leading up to Baby A's birth, during her stay in hospital and especially during the short time that she lived with her parents.

1.7 This SCR has been delayed because of the criminal investigation into Baby A's death. The mother has always, and continues to, deny hurting Baby A, however, in July 2019, the mother was found guilty of manslaughter and child cruelty and sentenced to 6 years imprisonment.

2. The Process

2.1 In February 2018, The Chair of the LSCB decided that this case met the criteria for a SCR as described in *Working Together to Safeguard Children 2015.* The reason for this decision was because

Baby A had died as a result of a head injury. In addition, a post-mortem had established that there was evidence of multiple old and recent injuries to the head, eyes and musculoskeletal system which were consistent with several episodes of non-accidental injury.

2.2 On the advice of the Crown Prosecution Service and the police, the Chair of the LSCB decided to delay the SCR because both family members and key practitioners were required as witnesses in the criminal trial and could not contribute to the SCR until after the conclusion of the trial. Following the conclusion of the trial, both the father and practitioners were able to contribute to the Review.

2.3 The detailed terms of reference are attached as an Appendix. The purpose, framework, agency reports to be commissioned and the particular areas for consideration are all described there. Ten agencies contributed reports to this Review. Not all of the areas for consideration included in the Terms of Reference are explicitly referred to within the report but they have contributed to the analysis, findings and recommendations.

2.4 *Working Together to Safeguard Children 2015* states that SCRs should:

- understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight;
- provide a sound analysis of what happened in the case, and why, and what needs to happen in order to reduce the risk of recurrence;
- be written in plain English and in a way that can be easily understood by professionals and the public alike

HM Government (2015:74)

2.5 The lead reviewer, Felicity Schofield, is independent of all the relevant professional agencies in the Essex area, has had no previous direct involvement with or knowledge of the family who were subject to the review and has had no previous involvement in a professional capacity with safeguarding practice in Essex. She is a social worker by profession.

2.6 Both the father and practitioners who knew the family well have contributed to this review. Their contribution has enabled the lead reviewer to understand better the events leading up to Baby A's death. Their input is greatly appreciated.

3. Period Covered by the Review

The ante-natal period (July 2016 to 6 January 2017)

3.1 Baby A and her twin brother were conceived by IVF after the parents had tried to conceive for a period of about 5 years. Both parents spoke good English and were described as a professional couple. The mother was in the UK on her husband's visa and had no recourse to public funds.

3.2 The maternity booking was made when the mother was 9 weeks pregnant. The issue of domestic violence appears to have been raised as a matter of routine by the midwife with no concerns identified, although the partner was present at the time, which would make such a conversation difficult.

3.3 The mother attended all her ante-natal appointments. From an early stage, routine scans identified that whilst one twin was growing normally, the other twin was much smaller although without any obvious abnormalities. The parents understood that the smaller twin may have complications when born.

3.4 The twins were born at 36 weeks gestation. Their paternal grandmother was staying with the parents in the period immediately before and after the births. Baby A was born with a defect in her oesophagus and a heart problem. Her birth weight was very low. Her brother was significantly heavier and was in good health.

3.5 Baby A was transferred to a neonatal intensive care unit in a neighbouring County the day after her birth. When she was just a day old, she underwent surgery to repair her oesophagus. As a result of this surgery she needed to be tube fed.

3.6 In the first few days after the twins' birth the parents showed appropriate concern about the welfare of both babies. The mother and twin brother were discharged from hospital after 6 days. The mother remained anxious about Baby A, who was being visited by her father.

Analysis

3.7 Both parents were involved in the ante-natal period and attended all the relevant appointments. They were prepared for the fact that Baby A was likely to have some additional health needs after her birth, although the nature of those needs could not be identified in the ante-natal period.

3.8 There was nothing about the behaviour of either parent which raised any concerns with health staff and after Baby A's birth the parents showed appropriate concern for her welfare.

The period when Baby A was in hospital and her brother was at home (January – May 2017)

3.9 Throughout Baby A's 4 month stay in hospital, she was regularly visited by her father although not every day. These visits were recorded as being short visits, approximately 15 minutes. Sometimes the paternal grandparents accompanied the father. In the first few weeks of her hospital stay, the father would ring the ward if he was unable to visit.

The father has questioned the reference to the length of his visits, saying that whenever he visited, it was at least 45 minutes to one hour. He emphasised the circumstances for the family at that time; he was working in Central London and had to dash to Cambridge after finishing work at 6.00p.m, travelling one hour, then spending time with the baby, and often getting back home late at night, with work the next day.

3.10 The mother visited Baby A approximately once every three or four days. She was advised by hospital staff that she could either bring the other twin with her to visit Baby A or stay in the hospital so that she could spend more time with baby A. However, the mother did not drive and there were no family or friends who were able to drive her to and from the specialist hospital, which was 50 miles from the family home.

3.11 Ward staff recorded some concern both about the mother's less frequent visits and about the length of visits by both parents, which were considered to be too short to get to know Baby A. Some four weeks after her admission, the parents were asked to visit earlier in the day and for longer periods of time. The records highlight the likely impact of the short visits on the parents' attachment to Baby A. It is not recorded whether the reasons for needing to spend more time with Baby A were made explicit, and if they were, the parents' response was not recorded. However, their pattern of visiting did not change. The family were also offered support from a psychologist although they did not actually meet with the psychologist because their ward visits did not coincide. The parents were given leaflets regarding the psychology service but they did not follow them up.

The father said that the parents were not given any leaflets or indeed offered the psychology service.

3.12 The father has explained that he took responsibility for Baby A whilst his wife looked after her twin brother. He ensured that he visited Baby A 5 days a week. The father regarded the point of his visits as being to check on Baby A's welfare and progress rather than to spend time with her. He worked in central London and therefore he had little option but to visit in the evenings.

3.13 At the beginning of February a health visitor visited the family home. The mother advised her that the paternal grandmother was expecting the mother to do all the housework, cooking etc whilst

the grandmother fed the baby. The mother also said that whilst her husband was generally supportive, he had changed since his mother had come to stay from India.

3.14 By the middle of February the parents, but especially the mother, were visiting baby A less frequently, for example the mother did not visit her for a period of over 2 weeks and the father did not visit for a period of 7 days. The length of their visits continued to be short. The father has explained that they visited Baby A less because she had recovered from her surgery and she was making good progress so they were less worried about her.

3.15 During this same period the mother attended the GP surgery for her post-natal check-up. The GP was unaware of the mother's unhappiness at home because the health visitor did not record her visit on the shared information system, Systmone, until two months later.

3.16 In March the health visitor visited the family home and the mother was more positive about the home situation. There were no concerns about the brother's care. The mother advised the health visitor that she and her husband played music to Baby A and took in pieces of clothing so that the baby would become more familiar with her family.

3.17 Throughout March the parents continued to visit once every few days, the mother less so. The parents were keen to speak to medical staff about Baby A's progress and often rang for updates, but spent little time with Baby A. At the end of March, the hospital records state that a speech and language therapist would contact the parents to ask them to visit more frequently and to establish whether there was anything the hospital could do to facilitate this. There is no record of such a conversation having taken place. The following day the same concerns were discussed in a multi-disciplinary meeting but there is no record of a conversation with the parents.

3.18 In April the police attended the family home after a call from the mother stating that her husband had beaten and manhandled her. However, on arrival the police were advised that there had been a verbal argument with her husband about her mother-in-law's critical attitude towards her. The mother had not been assaulted. No offence was recorded. The police offered the mother safeguarding advice. No further action was taken.

3.19 Information about the domestic abuse incident was passed to the health visitor on the same day and followed up with a phone call to the mother a few days later. The mother stated that the problems had been caused by her mother-in-law who had now returned to India. The mother advised the health visitor that she felt safe and that the baby was safe.

3.20 Towards the end of April, Baby A was able to begin feeding more normally, although she still needed to be tube fed as well. The parents continued to visit her once every few days but the mother

began to spend longer on the ward and to feed Baby A herself. The parents said they could not visit more often because of the distance to the hospital but the mother began to stay overnight.

3.21 Baby A transferred to a local hospital at the beginning of May. Hospital staff advised the father that ideally, they would like a family member on the ward with Baby A most of the time. The father said that he had not realised that this was their expectation. From then on, the parents visited Baby A more frequently and for longer. They received ongoing advice and support from both the nursing staff and speech and language therapists. Feeding was not easy but both parents persevered. No concerns about their approach were identified.

3.22 Baby A was discharged from hospital two weeks later. The father has described the discharge as 'chaotic'. Both parents had been trained in her specialist feeding regime and were regarded as competent to undertake it within their own home. They were keen to take Baby A home. No concerns had been recorded by the local hospital regarding the care given by either parent or about their relationship with each other.

Analysis

3.23 There is little information in the hospital records regarding either parent, essentially because there were no significant concerns. The recording was focussed almost exclusively on Baby A's health needs. The length of parental visits was not always recorded nor was the parents' response to conversations with hospital staff.

3.24 The concerns which had been identified about the timing and frequency with which the parents visited Baby A were raised early on with the father but were not pursued, even though the parents did not alter their visiting patterns to any significant degree and in fact visited less once Baby A was known to be making a good recovery. Practitioners have advised that no further action was taken because the concerns, whilst having been noted, were not considered to be serious. The father has advised that he was not aware that hospital staff were concerned that the parents were not spending enough time with Baby A. He believed he was visiting as often as possible in what were very challenging circumstances. The importance of spending time with Baby A in order to form an attachment to her was not an issue he considered or which he remembers being raised with him.

3.25 If the health visitor had liaised more frequently with the specialist hospital, she could have been made aware of these concerns and discussed them, together with Baby A's needs generally, with the mother at home in a less stressful environment. She could have explained to the parents the importance of forming an attachment to a baby as soon as possible.

3.26 It is noticeable that when Baby A transferred to the local hospital and expectations about parental visits were made explicit, the parents spent more time in the hospital. In addition, the practical problems of caring for the other twin should not be under-estimated, especially when the mother did not drive and there was no extended family support. Once again, the health professionals could have usefully discussed this dilemma during their home visits.

3.27 The community health records also do not include information about the parents and how they were coping with the demands of twins and hospital visiting or what their feelings were about Baby A's not insignificant health needs. There was no information in the records about the mother's support needs and who might be meeting them, especially given the difficulties she had reported to be experiencing with her mother-in-law. Practitioners have advised that whilst they did recognise that the mother was isolated, their absence of recording was a consequence of the mother's apparent ability to cope and the lack of any identified concerns.

3.28 When the parents started to become more involved in Baby A's care, once she had transferred to the local hospital, they presented as caring committed parents. They took it in turns to stay with Baby A and appear to have coped well with her care.

3.29 There was no discharge planning meeting before Baby A was discharged from the local hospital. Given that Baby A was to receive services from three different professional groups in addition to her GP and the specialist hospital, it would have been helpful to get the relevant professionals together to ensure that the professionals and the parents were clear about their respective roles and responsibilities.

<u>Baby A's time at home (mid-May to mid-August 2017)</u>

3.30 Baby A left hospital in mid-May aged four months old. Over the next three months, Baby A was seen by health workers from three different professions (the health visiting service, the children's nursing service and the speech and language service) at least twice a week. Each profession monitored different aspects of Baby A's health. No concerns about Baby A's care or her brother were identified.

3.31 The naso-gastric tube kept coming out during the first week. The parents sought advice on each occasion and health staff visited in response. The feeding problems continued and advice was sought from the GP, with the father taking Baby A to the surgery. Four days after the visit, the GP emailed the paediatrician seeking specialist advice.

3.32 The father has described this period as 'overwhelming'. He ensured that every appointment was kept but by taking time off work to attend appointments, he was having to work at home through the evenings. He and his wife had no time to talk. He said they had so many appointments that when they

were advised by the nurse to consult their GP, they could not find time to attend for a period of four days.

3.33 At the end of May, both the health visitor and the mother were concerned about Baby A's weight loss. The father had to take Baby A to the emergency department of the local hospital to get a replacement naso-gastric tube fitted after the original one had been accidentally damaged. The following day, the parents took Baby A to the GP regarding her weight loss. The GP had yet to receive a response from the paediatrician following her email two days earlier.

3.34 By the beginning of June, Baby A was recorded as having put on weight, although her weight remained very low (below 0.4 centile). There had been regular liaison between the various health professionals about her feeding problems.

3.35 The health visitor referred the family to a local children's centre for support. The referral included the information about the earlier incident of domestic violence and also stated that the mother now described her relationship with her husband as satisfactory. Baby A was described as being alert and smiling.

3.36 This referral was responded to three weeks later with a joint home visit from a children's centre support worker and the health visitor. During that visit, the mother said that she was a victim of domestic abuse in the form of arguments and controlling behaviour by her husband. These arguments tended to be about her mother-in-law who the father was skyping every week. The mother told them that her mother-in-law had sent over a white powder to put in the baby's feed. She did not put the powder in the feeds but was worried about what her husband would say if he found out. In response, the health visitor contacted the father to advise him not to give the powder to Baby A and it was discarded.

3.37 At a second visit, the mother agreed to a referral to the local multi-agency risk assessment conference (MARAC). Based on the available information, the risk assessment score was significantly below the threshold for referrals (5 v 15), however, professionals can still refer to the MARAC if they have concerns. Whilst unable to be specific, the health visitor was worried that honour-based violence might be an issue, especially when the mother returned to India. However, no further action was taken by the MARAC coordinator because the risk assessment score did not meet their threshold. This decision was not fed back to the health visitor who, in turn, did not follow up her referral.

3.38 As part of the criminal investigation, the father told the police that he took Baby A to see his GP in connection with her reflux medication. At the same appointment the father sought advice about Baby A's leg. The father had noticed that she could not put weight on it and that she seemed in pain

when he touched her toes. He had asked his wife who had said it might be cramp. The father has stated that the GP said there was no time to discuss this second concern and that he should raise it at his forthcoming appointment at the specialist hospital.

3.39 The GP records do not reflect this discussion. At interview, the GPs who saw Baby A during this time period confirmed that any reference to a painful limb would have been recorded. It should also be noted that there was no GP appointment in the days leading up to the appointment at the specialist hospital, which was at the beginning of July. The father remains adamant that he raised this matter with his GP but was content with the response because of the forthcoming appointment at the specialist hospital.

3.40 The parents and Baby A attended the appointment at the specialist hospital where a plan was agreed for her continuing feeding problems. The father advised the doctor that Baby A appeared to have some pain in her leg. Her legs were examined and nothing abnormal was identified. It is now known that Baby A probably had two fractures to her leg at this time. Expert witnesses in the subsequent court proceedings confirmed that as a result of this injury, Baby A would have been in pain with reduced movement to her leg.

3.41 In the four weeks before she died, baby A was seen by health professionals on 18 occasions, including two brief inpatient stays in two different hospitals. No concerns were recorded about either parent's care of Baby A by any professional during this period.

3.42 Even with the benefit of hindsight following Baby A's death, practitioners reported that there was nothing about the mother that gave them cause for concern. She was always welcoming, the flat was clean and tidy, and she was equally responsive to both babies.

3.43 The mother attended baby massage with both twins at the local children's centre for the first time. She discussed with the support worker how she felt about meeting the babies' needs and her relationship with the father. She said he checked her phone. The mother was given general support and advice about domestic abuse and the action she could take if she felt unsafe. The mother said she would like continued support with her emotional needs although there is no detail about why she wanted this additional support (presumably because of her 'controlling' husband).

3.44 Three days later the mother made a 999 call to the local police force, alleging domestic violence. The violence was alleged to have been part of an argument where the father had told the mother to leave the family home and that he did not want her looking after the children.

3.45 When a police officer arrived, the mother told the officer that she had been raped repeatedly by her husband over the last 7 years and that the twins had been conceived by rape. The last occasion

was said to have been 4 months earlier. The father has advised the lead reviewer that during this same visit he raised with the police officer the fact that the mother had smacked Baby A. There is no reference to this matter in the police records. The father was arrested and later released on bail with conditions not to contact the mother.

3.46 The mother and children were moved firstly to a police station and then to a hotel in a neighbouring County because she said she had no family or friends with whom she could stay. A community nurse visited them at the police station and again at the hotel because Baby A's naso-gastric tube had come out and needed to be re-inserted. The mother appeared to be coping well in what were clearly difficult circumstances. The police notified Children's Social Care (CSC).

3.47 On the same day as the mother's allegation, the father also rang the police and alleged that the mother had smacked Baby A. The call was wrongly diverted to the Metropolitan police. This information was not passed on to the Essex police, who were only notified of it as part of the investigation following Baby A's death. These two systems issues have been referred to the Independent Office for Police Conduct. The outcome is awaited.

3.48 Information was shared between the community nursing service, health visitor and GP, enabling Baby A's specialist feed to be supplied to the hotel where the mother had been temporarily placed. The GP practice updated their records for the mother and children but not the father.

3.49 Within days the mother had formally withdrawn her complaint to the police and refused to make a statement.

3.50 In a phone conversation with the children's centre support worker, the mother said that she did not want to be a single parent. She also said that her parents had encouraged her to return home because within her culture she would bring shame on her family.

3.51 Following that telephone conversation, the children's centre support worker rang the duty social worker who was already aware of the domestic abuse allegation. The support worker shared her concerns about the mother's vulnerability due to her isolation and Baby A's special needs. The children's centre support worker then made a referral to CSC which described the recent events and which also stated that 'there is no concern for the children's health and care needs being met'.

3.52The children's centre decided that following the allegation of domestic abuse, it was no longer safe for children's centre staff to undertake home visits alone to the mother and her twins. As a result, a further appointment was cancelled because there was no second worker available.

3.53 The case was allocated to a social worker who undertook a joint visit with the health visitor. CSC had had no previous involvement with this family. Baby A was undressed and weighed by the health visitor. There were no visible signs that Baby A had suffered any injuries. The mother repeated her allegations of rape and controlling behaviour by the father. The social worker noticed that the mother's attitude to Baby A was more negative than it was towards her twin brother. The mother said that she wanted her husband to return home, believing that he had 'learnt his lesson'.

3.54 Following the visit and the mother's reported desire for the father to return to the family home, the social worker put arrangements in place for a child protection strategy meeting.

3.55 The community children's nurse also visited that day at the mother's request in order to re-insert the naso-gastric tube which had, once again, been pulled out by Baby A.

3.56 In the early hours of the next day, the mother made an emergency call for an ambulance. Baby A was reported to have stopped breathing. Baby A was taken by ambulance to a hospital in a nearby London Borough where she died shortly afterwards. The mother had been advised how to undertake CPR by ambulance control but when the ambulance arrived there was no evidence of her having followed this advice as Baby A remained in her cot.

Analysis

3.57 The parents received significant amounts of help and support from community health professionals during the three month period that Baby A was cared for at home. It is evident from the records that community health staff responded promptly to the parents' requests for practical help and communicated regularly with each other. They used the same electronic recording system (Systmone) which meant that all those involved with the family could see what information was recorded.

3.58 What is absent from the records is information both about how the mother was coping with the demands of caring for Baby A together with her twin brother and also about either twin's developmental progress. The reason for this absence is because there were no concerns either about the parenting of the twins or about their development.

3.59 Baby A was consistently difficult to feed which, for a first time mother with no apparent support from either extended family or friends, a husband who was reported to be verbally abusive and controlling and a mother-in-law who she believed was being repeatedly undermining, must have been very difficult. However, the mother did not speak about her feelings and presented as coping well. She never complained.

3.60 The various professionals who were visiting the home did recognise the mother's isolation but were limited in their ability to address this issue. The referral to the children's centre was an appropriate response in the circumstances.

3.61 The four day delay in taking Baby A to see the GP in May was a good example of how demanding life was for this new family. The father said they had so many appointments that they just could not find the time to go. This delay in seeking medical advice could have been an opportunity for health professionals to consider the impact of their service provision from the family's perspective.

3.62 The GP should have sought more direct advice from the specialist hospital regarding Baby A's feeding difficulties. An email a few days after the consultation was not an appropriate response in the circumstances.

3.63 The father is adamant that he had raised concerns about Baby A's leg with her GP a few days before it was examined by a paediatric surgeon at the specialist hospital. However, that appointment has not been identified as part of this review and whilst the GPs who saw Baby A in the broad timeframe remember seeing her, neither remembers a reference to a painful leg and it is not recorded in their notes. It is not therefore possible to comment further on this matter.

3.64 The failure of the doctor at the specialist hospital to identify an injury to the leg at the beginning of July was a missed opportunity to safeguard Baby A. Further enquiries should have been made with the parents in order to establish why they thought Baby A's leg was painful. Whilst the reason for the appointment was the problem with her oesophagus, all doctors should be mindful of the potential for a non-accidental injury. The vulnerability of non-mobile babies to non-accidental injuries has been repeatedly identified in serious case reviews. Medical opinion has subsequently confirmed that at this time Baby A's leg would have been painful and her movement would have been restricted.

3.65 During the last four weeks of her life, when we now know that Baby A sustained other injuries in addition to her broken leg, there were 18 contacts with health professionals. At no time did the mother express any difficulty in caring for the twins. If Baby A was unsettled and/or grizzly, this was attributed to the difficulties with her feeding tube.

3.66 A more coordinated approach across the health professionals with a named Lead Professional and a single clinical care plan which identified lines of accountability and areas of responsibility would have helped the family. A lead professional could have taken overall responsibility for ensuring that all Baby A's health and social care needs were being met.

3.67 It would also have been helpful to identify when Baby A should be taken to her GP and when specialist advice should be sought from either the local or the specialist hospital. For example, at the

end of May when there were concerns about Baby A's feeding problems, approaching the hospital direct may have been more appropriate.

3.68 There was an appropriate and timely response to the mother's initial allegations of domestic abuse, although a referral to MARAC was not appropriate given that the risk assessment score was considerably below the threshold for such referrals. The health visitor's safeguarding lead should have advised the health visitor to seek more information if she was worried about honour-based violence before making the referral. Nevertheless, the MARAC coordinator should have provided feedback to the health visitor regarding the decision to take no further action. It was good practice for the GP to update the records, but this should have included the alleged perpetrator as well as the victim.

3.69 The support from the children's centre would seem to have been precisely the right approach for supporting this isolated mother but unfortunately there had been no opportunity to establish the support before the second allegation of domestic abuse which effectively ended the children's centre's involvement with the family. The centre's risk assessment, which indicated that two workers were required for a home visit, resulted in support not being offered to the mother and was at variance to other services where lone workers were continuing to visit the family home.

3.70 It is now known that the father made a counter-allegation concerning the mother smacking Baby A on the same day that the mother alleged rape. The local police were unaware of the father's telephone call, however, the mothers more serious allegation would have taken priority at least in the first instance.

Immediately after Baby A's death

3.71 In line with multi-agency procedures for child deaths, Baby A's body was examined by both a paediatrician and a police officer shortly after she had arrived at the hospital. The paediatrician was aware of Baby A's extensive medical history although the hospital could not access her records. No concerns were identified during this examination. Any marks on the body were attributed to Baby A's medical condition. Other evidence, such as the taking of blood and urine samples, known as Kennedy samples, was only partially gathered, despite a challenge to the paediatrician from the attending police officer.

3.72 The family home was visited by a police officer, two social workers and a specialist nurse on the day that Baby A died. Her death at that stage was regarded as 'unexplained'. Nothing of concern was identified within the home environment.

3.73 A strategy meeting was also held on that day and because the death was unexplained, it was agreed that there should be a daily visit to the family home by either the social worker or the health

visitor pending the outcome of forensic tests. The father was taken to see Baby A, released from his bail conditions and allowed to return to the family home with the mother's agreement.

3.74 Both parents wanted to resume their relationship and agreed to work with CSC. The father denied the allegations of rape. He also told the social worker that on occasion he had seen the mother smack baby A on the bottom and that sometimes the mother had become angry with Baby A because she was not as quick to learn as her brother. The social worker shared this information with the police.

3.75 Nothing of concern had been found at the examination immediately after the death of Baby A. A skeletal survey was then undertaken three days later and found multiple injuries which had occurred at different times, mainly but not exclusively in the few days prior to Baby A's death. The skeletal survey was completed on a Friday but the results were not passed on to either the police or CSC until the Monday, potentially leaving the brother at risk of significant harm over the weekend. The post-mortem was completed nine days following the death of Baby A.

3.76 A child protection strategy meeting was held on the same day that CSC were notified. Both parents were arrested and the twin brother was removed from their care six days after his sister had died. A child protection medical subsequently found no evidence of any bruising or injuries to the brother.

Analysis

3.77 The brother was potentially at risk in the six days between Baby A's death and CSC being informed of the outcome of the skeletal survey and his subsequent removal from his parents' care.

3.78 Expert evidence from the criminal trial confirmed that the facial bruising to baby A would not have been obvious at the time of death and was only found as part of the post-mortem process.

3.79. The local child death procedures required certain samples to be taken immediately after an unexplained death:

'Where the cause of death / collapse or factors contributing to it are uncertain, investigative samples should be taken immediately on arrival and after death is confirmed. Full guidance is provided to hospital staff on the taking of samples.' (Paragraph 18.1)

3.80 A strategy meeting was rightly held on the day of Baby A's death because her death was unexplained. The decision to introduce daily visiting pending the outcome of the post-mortem was an appropriate response.

3.81 There should not have been a delay of three days between the identification of the fractures and both the police and CSC being notified. The reason for the delay is not fully understood, possibly a

misunderstanding regarding the availability of child protection services at weekends. The process has since been reviewed and procedures changed to ensure that such a delay would not happen again.

4. Baby A's lived experience

4.1 Baby A had a traumatic start in life being born prematurely and spending her first four months in hospital. During that period her parents did not spend a great deal of time with her, both because she was in a hospital at some distance from the family home and also because the parents had her twin to care for.

4.2 Feeding was very difficult for Baby A, firstly because of the problems with her oesophagus and later because of the naso-gastric tube. She was reported to be averse to feeding orally even when it was possible and desirable.

4.3 Baby A was repeatedly recorded as having pulled out her naso-gastric tube. Whenever the tube came out, a nurse was required to re-insert it. These incidents account for the very high level of visits from community nurses. Sometimes it took several attempts to re-insert the tube. On one occasion Baby A was described as being exhausted by these attempts.

4.4 When Baby A was first discharged from hospital, she had delayed gross motor skills as a consequence of her health problems and prolonged stay in hospital. This delay in her development was temporary.

4.5 Baby A was injured on at least three separate occasions before her death. Her leg was broken in two places between 4 and 6 weeks before her death, her skull was bruised between 3 and 7 days before her death, her ribs were broken between 2 and 4 days before her death and her skull was fractured in the final 12 hours of her life. She had therefore experienced considerable physical abuse during those last weeks of her life.

5.0 The Parents

5.1 The parents had tried to conceive for a number of years and were looking forward to the birth of the twins.

5.2 Following the birth there was a difficult period when Baby A was in hospital at a considerable distance from the family home. During this time the father took the main responsibility for visiting Baby A, whilst his wife cared for the twin brother. Once Baby A had left hospital, the father took her to her many appointments. The father regarded this approach as the best way to cope with the practicalities of their situation.

5.3 At no time, either whilst Baby A was in hospital or when she was at home, did either parent advise any of the workers who visited them that they were experiencing difficulties in caring for the twins, although the father has subsequently described the situation as a whole as overwhelming. They just managed as best they could.

5.4 The mother continued to deny any difficulties during both the care proceedings and in the criminal trial, where she pleaded 'not guilty' to the charges against her. During the criminal trial, the mother's friends also stated that the mother appeared to be coping well.

5.5 The parents' relationship was strained. Divorce proceedings were said to have been commenced in India, although this was not known prior to Baby A's death. The mother made allegations of coercive control and domestic violence, which the father denied. Although she did involve the police, the mother decided not to pursue her allegations. Some of her allegations were later proven to be untrue. At the time of Baby A's death, the mother had wanted her husband to return home but he was prevented from doing so by bail conditions.

5.6 After Baby A's death, as part of the subsequent court proceedings, the father said that from around July he had noticed that the mother was short-tempered with Baby A because she was developmentally behind her brother, occasionally 'tapping' or 'smacking' her bottom. When Baby A did not want to take a bottle, both parents called her 'lazy'.

5.7 The father has expressed his concern to the lead reviewer that his views were not sought before a referral was made to the MARAC and that his concerns about the mother's treatment of Baby A were not considered at the time that his wife made the serious allegations of rape and domestic abuse.

5.8 During the criminal trial, it was suggested that the mother had 'played down' the extent of Baby A's problems, describing both twins as 'the same' in conversations with both her husband and members of the extended family. However, practitioners who had visited the family home did not perceive the mother's attitude towards Baby A as a cause for concern, reporting that it is not unusual for parents to 'normalise' their children's special needs.

6. Changes in Service Delivery since Baby A's death

6.1 The three health professions and the children's centre are now all managed as a single Children and Family Wellbeing Service with a single set of policies and procedures. As a consequence of this reorganisation, the response to referrals for additional support is quicker.

6.2 If a similar domestic violence allegation was made to a health visitor today, an independent domestic violence adviser (IDVA) would be allocated within 24 hours.

6.3 The same lone working policy now operates across the Children and Family Wellbeing Service.

6.4 The local hospital has introduced discharge planning meetings for children with complex health needs.

6.5 A more robust procedure for taking Kennedy samples has been introduced by the hospital where Baby A died.

6.6 The London hospital which undertook the skeletal survey after Baby A's death has reviewed and changed its procedures regarding communication with the police following the identification of safeguarding concerns.

7. Lessons learned and findings

Overall:

7.1 There was nothing about this family that might suggest that their daughter would be deliberately harmed. The parents were not previously known to any safeguarding service and no safeguarding concerns had come to light either during the ante-natal period, during the four months that Baby A was in hospital or in the short period that she lived at home.

7.2 The parents were Indian with the mother having moved to this country relatively recently and having no recourse to public funds. She had no family living in this country. Both parents' English was good. However, practitioners could have been more enquiring about the parents' culture and its potential impact on their care of the twins. Practitioners have reported that they were mindful of the potential impact of the parents' culture but did not identify any issues or concerns, which is why their records contain so little reference to culture.

7.3 The parents did not tell anyone that they were struggling with the care of the baby A, if indeed they were. However, the parents were managing a stressful and demanding situation with very little support from either friends or family. The focus of the recording by health professionals was on Baby A's complex needs. A more holistic perspective which considered the needs of the whole family, including the recording of developmental milestones for both babies and a description of the family's support networks should have been included.

7.4 It would appear that in the absence of her husband, the mother found it difficult to care for Baby A. The mother never said that caring for the twins on her own might be a problem but this possibility should have been considered and discussed with her once the couple were separated.

7.5 A number of health staff did examine Baby A after she had sustained injuries, however, in the absence of any concerns about the way she was being looked after, it seems that if she was fretful or upset, her behaviour was attributed to her health problems. The possibility that she had been deliberately harmed was not considered.

Specifically:

Discharge meetings for babies and children with complex health needs

7.6 A discharge planning meeting could have established a more coordinated response to service provision at an early stage.

Recommendation: Hospitals should consider holding discharge planning meetings for children with complex needs. (This has already been actioned by the local hospital).

Coordinating services for babies with additional health needs & the need to identify a lead professional

7.7 Baby A was seen by health professionals at far greater frequency than would be the case for a baby without her health needs. During the three months that she lived with her parents she was generally seen at home at least twice a week by representatives of one of the three professional groups that were delivering direct services to her. In addition, she had appointments with two local hospitals, a specialist regional hospital and her GP.

7.8 The records evidence very regular information sharing between the various professionals. However, there was no lead professional and no coordinated approach to the provision of services, the liaison with the hospitals and with the GP.

7.9 The level of visiting was intrusive to the family, even though it was often requested and never complained about. A lead professional could have discussed the overall situation with the parents and developed a better understanding of how they were managing.

Recommendation: Health providers should consider the need for a lead professional and shared clinical care plans for babies and children with complex health needs.

Responding to allegations of domestic abuse

7.10 The allegations of domestic abuse were responded to promptly and sensitively. A risk assessment was undertaken and the mother was given appropriate advice. The health visitor consulted her safeguarding lead and made a referral to the MARAC, despite the fact that the risk assessment score was significantly below the threshold for referrals (the score was 5, the threshold was 15 or above).

7.11 Whilst it was good practice for the health visitor to consider the risk of honour-based violence there was insufficient information to enable the police to take any further action.

7.12 Thresholds are in place in order to ensure that scarce resources are directed towards those families who are most in need. There is provision for professionals to refer cases to the MARAC which fall below the threshold based on professional opinion. In this case there do not appear to have been exceptional reasons which warranted such a referral. The safeguarding lead should have advised against making a referral at that time and encouraged the health visitor to acquire a more detailed understanding of the situation. If there were exceptional circumstances which warranted a referral despite the low risk assessment, the safeguarding lead should have identified and agreed the reasons before the referral was made.

7.13 The MARAC coordinator should have advised the health visitor of the outcome of her referral so that she was aware that no further action was being taken. Similarly, if the health visitor had no response from the MARAC following her referral, she should have followed it up.

Recommendation: Safeguarding leads should be reminded of the importance of ensuring evidenced referrals to the MARAC.

The MARAC coordinator should be reminded to provide feedback to referrers regarding the outcome of any referral

7.14 After the second allegation of domestic abuse, the children's centre decided that it was no longer safe for their workers to visit the family alone. This decision was made in isolation of the other services being provided to the family, all of whom continued to send lone workers to visit the family home.

Recommendation: If an agency decides that it is not safe for their staff to visit an address, they should notify their decision to other workers who are also known to be visiting the same address.

<u>Injuries to non-mobile babies and children</u>

7.15 A few weeks before her death, the parents advised a paediatric surgeon that Baby A's leg appeared to be hurting her. How would a parent know that a baby's leg was hurting her? The paediatric surgeon failed to seek further information from the parents. Whilst the leg was examined, fractures to the tibia and fibia were not identified.

Recommendation: All professionals working with non-mobile babies to be reminded of the importance of being alert to and suspicious of physical injuries to this vulnerable group.

Timely Communication between police forces

7.16 Essex police only became aware that the father had alleged that the mother had smacked Baby A after her death because the allegation was wrongly reported to the Metropolitan police and not subsequently passed on to the Essex police force.

Recommendation: The Safeguarding Partnership should consider the implications of the Independent Police investigation once the outcome is known.

Compliance with Child Death procedures

7.17 A strategy meeting was rightly held on the day of Baby A's death and because her death was unexplained, the decision was taken to introduce daily visiting pending the outcome of the post-mortem. This was an appropriate response. There were no grounds to take any additional safeguarding action at this stage.

7.18 Some Kennedy samples were not taken at the time of Baby A's death, despite the procedures being clear that this is a requirement for all unexplained and unexpected child deaths. The failure to do so appears to have been the result of a misconstruing of the coroner's directions by the hospital in a neighbouring London Borough.

7.19 There was a delay of three days between the identification of the fractures at the skeletal survey and Police and CSC being notified. The reason for this delay has been explored but remains unclear. However, the procedures have been changed to ensure that such delays will not happen again thereby reducing the risk of harm to siblings.

Recommendation: The Strategic Child Death Overview Panel ensures that Kennedy samples are now being taken as required by the Child Death procedures.

8. Recommendations:

8.1 Hospitals should consider holding discharge planning meetings for children with complex needs.

8.2 Health providers should consider the need for a lead professional and shared clinical care plans for babies and children with complex health needs.

8.3 Safeguarding leads should be reminded of the importance of ensuring evidenced referrals to the MARAC.

8.4 The MARAC coordinator should be reminded to provide feedback to referrers regarding the outcome of any referral

8.5 The Safeguarding Partnership should consider the implications of the Independent Police investigation once the outcome is known.

8.6 All professionals working with non-mobile babies should be reminded of the importance of being alert to and suspicious of physical injuries to this vulnerable group.

8.7 The Strategic Child Death Overview Panel should ensure that Kennedy samples are now being taken by all hospitals in the area, as required by the Child Death procedures.

Addendum to the Serious Case Review report – Baby A

Introduction

During the process of this report being quality assured by the Essex Safeguarding Children Board, it was widely considered that the report lacked a degree of balance as a result of Mother's perspective and experiences not having been included in the SCR report.

Two previous letters sent by the Essex Safeguarding Children Board in July 2018 and September 2019 to Mother's solicitor, informing Mother about the Review and inviting her to contribute to the Report, had not elicited a response. However, following a third attempt to make contact with Mother in January 2020, this time via the prison, Mother said that she would like to be involved. She said that she had not received the first two letters.

This addendum report provides a summary of information obtained from Baby A's Mother following a face to face meeting between her and two senior representatives from the Essex Safeguarding Children Board on 24 February 2020, which enabled her to go through the report and ask questions. In addition, she was allowed to keep a copy of the draft SCR report to further reflect on the content and so that she could provide written comments for inclusion in the published version as an addendum report, and the Essex Safeguarding Children Board received this on 16 March 2020. A further meeting was held with Mother on 9 July 2020 via conference call to agree the final content.

Mother's input has been very helpful in helping us to understand her experiences and to help clarify certain points. There is no doubt that taking part in this process was extremely upsetting for Mother and she was visibly distressed during the meeting at the prison. However, we are grateful for her contribution and also for the support offered to Mother from the HM Prison Service.

Mother's perspective

Mother went to University in India to study for a Master's degree in Social Work. All her family live overseas and she has no-one in this country outside prison to support her or argue her case for her. She married Baby A's father in 2009 and this was an arranged marriage. Once married she came to the UK on her husband's passport but she herself had no recourse to public funds. Mother described her husband as being very wealthy and as such he held the money and the passport.

The children were conceived by IVF after 7 years of marriage. From the first scan the doctor was very concerned about Baby A and had told the parents to be prepared anytime for their unborn daughter to die. Both parents asked the doctor numerous questions about what the problems might be, but the doctor was not able to say with any certainty at that time. The twins were born by emergency C-section on the 6th January 2017.

Mother explained that Baby A was born prematurely with significant health issues which required her to remain in hospital for the first four months of her life. Baby A underwent an operation on her oesophagus the day after she was born which was unsuccessful and the doctors were reluctant to undertake a further operation due to the potential risks involved. The reason why Baby A needed to remain in hospital for the first four months of her life was to allow the hole in her oesophagus to heal. In those four months Baby A went through six constructs in the radiological department.

Throughout Baby A's 4 month stay in hospital, Mother said that her husband used to visit the child regularly. If he was not able to visit both parents would make sure that they called the hospital to enquire about their daughter's well-being (at least 3 times a day). When Mother was unable to visit her daughter in the hospital with her husband, he ensured that she had contact with Baby A via FaceTime, in addition to sending her pictures and videos of their daughter.

Mother said that once discharged from hospital, Baby A continued to receive nursing care every other day and was fed through a naso-gastric tube. In addition to the home visits by health practitioners, (47 in total), her daughter also had various GP and hospital visits within this three-month period. Mother said she herself was also experiencing a lot of post-operative pain at that time. (The SCR report - 1.4 refers to the family being overwhelmed with appointments).

Baby A's father would usually take their daughter to the hospital while her mother would arrange all Baby A's appointments and make sure that everything was organised. Whilst both parents would try

to take Baby A together to the hospital, this was not always possible and they did not feel this was the right environment for their son. However, Mother emphasised that they did not miss any appointments or any phone calls from the health professionals involved in their daughter's care.

Mother said that both parents were always worried about their daughter and continued to ask questions of medical staff about her health. The mother maintained that if any of the medical staff had had any concerns about them as parents, then she was sure that they would have raised this with the GP or the health visitor or indeed with themselves.

The mother has no recollection of being offered any support from a psychologist either before, during or after giving birth. (The SCR report refers to the hospital offering this support via giving the parents an information leaflet about their psychological services. However, it would appear that handing out an information leaflet was not considered by Mother to be an offer of psychological support).

Baby A's naso-gastric tube kept coming out almost every other day. Both parents raised concerns with the Speech and Language Therapist regarding their daughter not having any paediatric appointments which they thought was really important. The mother believed the Speech and Language Therapist had then raised this with the GP.

Mother recalled an occasion when her husband having returned home from work lifted up their daughter and helped her to stand however she looked as though her leg was in pain. The mother observed that Baby A used to wriggle about a lot and wondered if it might be cramp, so they agreed to monitor her overnight with a view to discussing their concern with the G.P. the following morning as they already had an appointment to discuss her reflux medication. When Baby A's father took her to the G.P, the father said that he had raised his concern about her leg, however the G.P was reported to have told him that he would have to make another appointment as it was a different issue .

The following day both parents (and the twins) attended an appointment for Baby A to see a health specialist in an out of county hospital and they raised their concern with him about her leg. Mother said that the doctor did 'a throw test' on her leg and concluded that he was not concerned.Mother raised the issue and her concerns that the doctor missed whether there was anything wrong with Baby A's leg.

Mother said that she does not know and is concerned why no health professional picked up that her daughter was in pain, especially as health visitors used to check Baby A's weight every week and she

was fully undressed at that time . The health professionals used to hold Baby A all the time to make sure that she was alright.

Similarly, Mother said that she attended baby massage with both her children at a local Children's Centre. She would massage her daughter and a nurse would massage her son. However, Baby A did not appear to like the massage and would cry throughout. When the nurse asked her why Baby A was crying, Mother explained that her daughter would always cry when being massaged or bathed.

Mother feels strongly that her daughter's health problems were more significant than initially thought by professionals.

Mother confirmed that she did make a 999 call to the police, as described in the SCR report due to an argument with her husband. She said that it came about when her husband was on Skype with his parents overseas and he was showing the twins to them. The call coincided with the time for Baby A's medication which was very important to her. Baby A's Mother asked her husband a couple of times to allow her to give their daughter her medication (which she had to administer through a tube), however he did not comply and continued holding their daughter which started the argument.

Mother said that her husband did not tell her to leave (as recorded in the SCR report) and that he wanted her to look after their children. She is clear that she did not have any contact with her mother-in-law when she returned to India (following her stay with them in the UK) and it was her own mother who had advised her not to bring up her children without a father and it was nothing to do with her culture or shaming her family.

Following the argument she remembers her husband telling the police officer that she had smacked their daughter. The mother said that she only affectionately tapped Baby A's bottom while cradling her as a soothing gesture.

Baby A's Mother said repeatedly and consistently that she did not know how her daughter sustained her injuries and that she felt that Baby A's health issues were much more significant than was initially thought by professionals. She said that she has not been able to grieve for either of her children and "can still smell them". Her distress is compounded by the fact that her own parents did not have the chance to meet either of their grandchildren.