Serious Case Review

Baby Q

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March 2017

1. Introduction

1.1. On 24th March 2016 Baby Q was brought to the child health clinic by her mother and was seen by a Community Staff Nurse (CSN) who noted that the baby looked thin and lethargic and poor weight gain was recorded. Baby Q cried when her mother undressed her to be weighed and the CSN observed that the baby's right leg was very swollen. Mother said she had been worried about this leg and they had recently been seen on Ward 7 at High Wycombe Hospital (HWH) but the doctors could find nothing wrong. (However, Baby Q was seen on Ward 7 on 25th February 2016 because of concerns about her left leg.) After consultation with the Paediatric Register at HWH the CSN called an ambulance. Whilst waiting for the ambulance to arrive Baby Q, who was observed to be hot and drowsy, became unresponsive and had to be stimulated to arouse her.

1.2. At Stoke Mandeville Hospital an x-ray revealed a fracture of the right lower limb. It was felt that the injury was non-accidental, social care was informed and an initial investigation undertaken. Later that evening whilst undressing Baby Q to be weighed it was noted that there was a subtle deformity of the left forearm and two linear marks on this forearm. A subsequent x-ray and a skeletal survey the next day revealed fractures to all four limbs and to her ribs. The parents were unable to give any explanation for these injuries.

1.3. In accordance with Regulation 5 of the Local Safeguarding Children Board Regulations 2006, Buckinghamshire Safeguarding Children Board instigated a Serious Case Review in line with the criteria set out in Working Together 2015[1].

1.4. In setting out the terms of reference the Case Review Panel identified the following areas to be addressed by the review:

[1] HM Government (2015) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*

- **Assessments**: what assessments did each agency undertake regarding the parents and/or Baby Q. What was the quality of those assessments?
- **Plans**: were any plans identified for the parents and/or Baby Q? Were they implemented effectively? Were internal agency procedures followed?
- **Risk**: what risk factors were identified either before or after the birth of Baby Q?
- **Information sharing**: how effectively did each agency share information about this family with other agencies?
- **Inter-agency working**: did agencies work effectively with one another? Was there co-operation?
- **Working with the family**: were there any factors that enhanced or impeded each agency working effectively with this family?

1.5. The time frame for the active review is from the point of the mother's pregnancy (approximately 20th April 2015) until 24th March 2016 when Baby Q was admitted to hospital.

2. The Review Process

2.1. This Serious Case Review adopted a systemic approach based on the model developed in Wales[2] for undertaking Child Practice Reviews which have replaced Serious Case Reviews. A key feature of this approach is to bring together agencies and practitioners in a collective endeavour to reflect and learn from what has happened in order to improve practice for the future. The focus is on accountability not culpability, on learning and not blame.

2.2. A Case Review Panel was convened to steer the process. It was made up of representatives from Buckinghamshire CCGs,

[2] Welsh Government (2013) *Protecting Children in Wales: Guidance Arrangements for Multi-Agency Child Practice Reviews*

Buckinghamshire Healthcare NHS Trust, Thames Valley Police, HB Law Plus and Buckinghamshire Safeguarding Children Board. It was chaired by a senior manager from Children's Social Care.

2.3. The Panel commissioned summary analysis reports from each agency involved with the family, produced a chronology of events and began the learning process by identifying significant issues and clarifying questions and areas to explore. They also identified the practitioners to be invited to the learning event, explained the process to them and helped them with preparation. Participants were asked to reflect on their involvement with Baby Q and her family thinking specifically about:

- Assessments
- Decision making
- Actions
- Interactions with other professionals and services
- Areas of effective practice
- Areas where there could have been some improvements

2.4. At the heart of this review was the Learning Event which was held on 6th February 2017 from 9.30 until 4.00 and which was facilitated by the Reviewer. There were 15 participants:

- Health Visitor
- Community Staff Nurse
- Community Nursery Nurse
- Current Social Worker
- Initial allocated Social Worker
- GP
- Advanced Nurse Practitioner from Minor Injuries Unit
- 2 Paediatric Consultants
- 2 Ward Sisters
- Deputy Sister

- Detective Constable, Thames Valley Police
- Panel Chair
- Panel representative from CCGs
- BSCB Business Manager
- BSCB Administration Officer

2.5. Each participant described their involvement with the family, highlighting the actions they took and the reasons underpinning them as well as their assessments of the situation at the time. This was done as chronologically as possible. After each input there was an opportunity to ask clarifying questions, engage in discussion and begin to identify key issues and learning points. Once everyone had contributed they moved into small groups for further reflection on the emerging learning and to think about some possible actions and recommendations.

2.6. Unfortunately, due to illness, there were no representatives from the midwifery service at the Learning Event. However, the Reviewer and CCG Panel member had a separate meeting with the Specialist Safeguarding Midwife and a Community Midwife at a later date.

2.7. The discussions at the Learning Event were carefully recorded and together with the notes from the meeting with midwives, Panel deliberations and individual agency analysis reports form the basis of this overview report.

2.8. The paternal Grandparents of Baby Q who are now caring for her and her two siblings were invited to contribute to this review. Following a meeting held with their allocated social worker they decided not to take part in the SCR process.

2.9. The reviewer and author of this report is an independent consultant with considerable experience of undertaking serious case reviews. She was also involved in developing the model of Child Practice Reviews in Wales.

3. Summary of Circumstances Leading to a Serious Case Review

Family composition

Relationship	*Date of Birth*	*Ethnicity*
Baby Q	01/01/2016	British Asian
Mother	26/04/1993	British Asian
Father	23/11/1991	British Asian
Brother	08/08/2013	British Asian
Sister	27/06/2014	British Asian

3.1. Whilst this family were not known to Children's Social Care during the active period of this review, their mother was known to the Department from 2002 to 2009 during which time there were eight referrals. The referrals centred on maternal grandmother asking for support with mother whom she described as having learning difficulties and at times displaying difficult behaviour. She also described marital problems and that she had health issues. Later maternal grandmother described difficulties in managing all three of her children because of their behaviour. Several initial assessments were undertaken and advice given but no ongoing role for Children's Social Care identified.

3.2. When mother was 17 years of age a referral was received from the Police as she alleged that she had been forced to drink three bottles of wine and have sex with her then school aged boyfriend. Mother subsequently refused to engage with the Police and would not co-operate with the investigation.

3.3. As children Baby Q's parents both had a statement of special educational needs (SEN). Mother attended a special school and was described as having moderate learning difficulties and visual impairment due to a congenital malformation of the iris resulting in a total lack of sight in her left eye. Father also attended a special school because of moderate learning difficulties. He was also reported to have emotional and behavioural

difficulties and there were concerns about his abusive and threatening behaviours towards other children, both verbally and physically. He was arrested five times between 2011 and 2016 for matters involving public disorder, theft, arson, robbery and assault.

3.4. Baby Q's parents married in 2012 and initially lived with the paternal grandparents. During this period there were no concerns about the care of the older siblings, although they had been assessed as potentially vulnerable by the health visiting service and offered a 'Universal Plus Service'. This decision was based on risks identified including mother's learning difficulties, maternal drug and alcohol misuse prior to her first pregnancy and her strained relationships with her extended family. Around the time that mother became pregnant with Baby Q the family moved from the paternal grandparents' home into their own accommodation in March 2015.

3.5. Eight weeks into her pregnancy Mother attended a booking appointment at Wycombe Birth Centre. The practice attached midwife undertook a Routine Enquiry. No domestic abuse was revealed. A mental health assessment was also undertaken and mother disclosed a history of depression after the birth of her son which did not need medication. She also said she had dyslexia and ADHD. She was booked for Consultant led care as her son had been small for gestational dates.

3.6. During the pregnancy mother missed two appointments for a glucose tolerance test (GTT), so it was not until 37 weeks that she was identified as suffering with gestational diabetes mellitus.

3.7. Mother's contact with her GP surgery was somewhat erratic. Her pattern was to make appointments on the day for acute issues and to request sick notes. This meant that during the period of this review she had contact with at least six different GPs. There are numerous recordings of her failing to attend for booked appointments with practice nurses and doctors. In July 2015 the surgery received a letter from the DWP health assessment advisory service to say mother had attended for an assessment of

entitlement to benefits and had said she had thoughts of jumping out of a window although she did not think she would ever do so. One of the GPs did ring her, assessed her as not at immediate risk and booked an appointment for her a few days later which she did not attend.

3.8. Baby Q was born on 1st January 2016 and discharged home two days later. The community midwife attempted two home visits on the 4th and the 5th but was unable to gain access on both occasions. It later transpired that mother and Baby Q were staying with paternal grandparents.

3.9. The Health Visitor carried out a routine new birth visit. No concerns regarding the care of Baby Q were identified at this visit. An appointment was arranged for a further home visit. Over the next weeks concerns centred on Baby Q's poor weight gain and consequent faltering growth and difficulties in engaging with the family because of missed appointments or not responding to telephone calls. Despite reminders, mother failed to take Baby Q for her repeat hearing test and for her six weeks development check. The parents did explain that it was not easy for them to get to some appointments as they did not drive and needed a lift.

3.10. On 25th February 2016 mother attended clinic with Baby Q. She reported that she was concerned about Baby Q's left leg. The Health Visitor noted that there was little movement in this leg although there was no sign of injury in any way. The baby's weight was poor and her appearance pale. The Health Visitor contacted Ward 7 at HWH but was informed that referrals have to come via a GP. The Health Visitor then contacted the Minor Injuries Unit (MIU) and Baby Q was taken there by both her parents.

3.11. At the MIU Baby Q was seen by an Advanced Nurse Practitioner and then, after consultation with the on- call Paediatrician, was sent to Ward 7. The baby was examined and observed for four hours. It was noted that weight gain was poor and a systolic heart murmur was also noticed. The outcome was that there was no need for an x-ray as there was no redness or swelling, all joints had good passive movements and the baby was not in any pain. There was a follow up plan of a feeding regime for the failure to

thrive, with the Health Visitor to review in two weeks and a subsequent Consultant clinic follow up in four to six weeks.

3.12. On the 29th February 2016 at 00.34 a 999 call was made from the family's landline and a female voice asked for the police then the line went dead. When the Call Handler rang back a woman answered and said it had been her young daughter dialling by mistake but then admitted it was her. A male voice could be heard in the background. Both parties became aggressive with the Call Handler when she said that police were being sent round to check everything was all right. Uniformed Patrol Officers were allowed entry and spoke to both adults present. The children were in bed asleep and no offences were disclosed. Apparently there had been an incident of a similar nature in May 2015.

3.13. Between the 26th February and the 24th March the Health Visitor made two unplanned home visits and her and her colleagues were proactive in informing the GP surgery of the visit to Ward 7 and in making an appointment for Baby Q to be seen by a GP. Unfortunately, the family failed to attend both the initial and the rescheduled appointment, citing problems with transport.

3.14. On 24th March 2016 mother attended the clinic with Baby Q which resulted in Baby Q being taken by ambulance to Stoke Mandeville Hospital. When x-rays revealed numerous unexplained injuries child protection procedures were immediately initiated,

4. Learning Arising from the Review

4.1. **Assessing and evidencing risk and vulnerability:**

The midwifery service and health visiting identified potential risks in this situation. The midwife highlighted previous mental health issues following the birth of Baby Q's older brother and noted that mother described herself as having dyslexia and ADHD. The Health Visitor, who had had contact with the family periodically since the birth of their first child, assessed that they needed extra support and they were therefore

offered a Universal Plus Service[3]. The GP surgery also recognised that this was a vulnerable child especially in the light of her faltering growth and the frequency with which her parents failed to bring her to an appointment. (At the time the surgery did not have a system for flagging the notes of vulnerable patients and children but this is now in place.)

4.2. Whilst potential risk to Baby Q had been assessed the problem was in evidencing if anything detrimental was happening to this baby. Professionals noted that she looked clean and cared for and observed good interaction between mother and baby. Mother, herself was always well presented. With hindsight it was recognised when the family moved out of paternal grandparents home to accommodation of their own was a very significant event, as whatever support the parents had received from their extended family was inevitably reduced. However, the Health Visitor was very aware of this and had discussed it with mother. The Health Visitor was also aware that on home visits in connection with Baby Q's siblings mother sometimes looked to paternal grandparents to answer any questions or to describe how the children were doing which made the Health Visitor question how much care the mother was actually providing. Once the family had moved, however, there were no indications at home visits of the parents not coping and the home was always clean and in good order.

4.3. **The difficulties in assessing parenting capacity when an adult has learning difficulties:**

There was a considerable amount of historical information about Baby Q's parents. Both had had statements of special educational need and both had attended special schools and both had been described as having moderate learning difficulties. In addition father was reported as being abusive and threatening towards other children. However, this information did not 'follow them' into adulthood and was unavailable to the professionals working with Baby Q and her siblings.

[3] **Universal Plus Services** *are offered to families with children 0-5 years with specific issues. Where families are identified to be potentially vulnerable and at risk of poorer outcomes additional levels of support proportionate to the level of need can be provided.*

4.4. Despite not having access to this past information professionals, such as the midwife, did recognise some degree of learning difficulty in mother partly because she talked about her dyslexia and ADHD. The Health Visitor, because of her contact with the family over time and because of her local knowledge, was aware of the special school that mother had attended and how it equipped its pupils with social skills. This meant that mother would present well initially and if contact with her was relatively short term or one-off then it would be hard to detect if she had any learning difficulties let alone assess to what degree and how that might impact on parenting. In addition when the family lived with the paternal grandparents there were multiple carers of the children making it difficult to quantify the parenting skills of the mother and father and therefore how they would care for Baby Q. There had been no concerns about Baby Q's elder siblings.

4.5. The Health Visitor, concerned about Baby Q's poor weight gain and faltering growth, did explore with mother in some detail how much Baby Q was taking in her feeds. Mother's responses and her showing how much on the bottle should have meant that Baby Q would have been putting on weight. Was mother showing the Health Visitor what she thought she wanted to see? How would it have been possible to establish the truth apart from being present at every feed? In retrospect did Baby Q's systolic heart murmur account for or contribute towards her poor weight gain?

4.6. **The role of the father:**

Despite being registered as mother's carer because of her visual impairment and learning difficulties, Baby Q's father was little in evidence when professionals had contact with the family. Mother brought Baby Q to appointments either alone or with a member of her extended family such as paternal grandmother and sometimes maternal grandmother. Mother described how her and her husband shared the care of all three children but professionals were unable to observe the interaction between the father and Baby Q and her siblings.

4.7. It would seem that Baby Q's father 'did not make himself available' to professionals. The Health Visitor saw the father for any length of time on only one occasion when she made an unannounced home visit the day after Baby Q had been seen on Ward 7. There were other visits when she was aware he was in the house but in another room and on reflection feels she maybe could have been more proactive in inviting him to join the discussion. However, at the time she had no background information about him and did not know of past concerns about his challenging behaviour and aggression towards peers when at school.

4.8. Baby Q's father had only infrequent contact with his GP surgery and had made a couple of visits to the Minor Injuries Unit for minor ailments. The midwifery service had no contact with him as he never accompanied his wife to appointments and there was no home visit post natal as the midwife had wrong information about the family's whereabouts. Mother had actually gone to stay with the paternal grandparents for a few days after the birth of Baby Q and was therefore not at her home address.

4.9. **The problems in working with families who are difficult to engage:**

It was difficult for professionals to access and engage with this family, especially from the time they moved into their own accommodation in April 2015. This non-engagement was manifested in numerous missed appointments, lack of clarity in terms of their whereabouts or professionals being unable to gain access on home visits. On the whole it would seem that this was more to do with the family's chaos than any hostility towards professionals or deliberate non-compliance, (except maybe for the period in March between the two hospital admissions). It should also be taken into account that these young parents had three children under 3 years of age and often cited problems of transport for not being able to keep appointments. However, it also meant that a lot of professional time and energy was spent in trying to ensure that Baby Q was brought to appointments or that the family were seen at home.

4.10. The family's disorganisation made it difficult for professionals to provide continuity of care. For instance mother tended to book GP appointments on the day when the presenting problem was addressed, but as she saw at least six different GPs during the period of this review therefore any exploration of other issues was compromised. It should be noted, however, that this approach to GP care was not unusual. The wider family also had a pattern of booking appointments on the day and then sometimes not turning up. Indeed this would also seem to be an issue across the community served by this surgery. However, for Baby Q it meant she missed some important things such as her 6 week check.

4.11. **Information sharing:**

At the Learning Event as each professional outlined their involvement with Baby Q and her family a detailed picture emerged. Participants said they had learnt a lot and how everything 'slotted into place' and how they now had a greater understanding of the situation. However, this is hindsight and so the issue is how much of this information would it have been possible to access at the time, what inhibits the flow of information and what is the impact on professional assessments and intervention? For instance historical information from the parents' childhoods was not available to the professionals involved with them as adults. Although it might have helped in the assessment of parenting capacity, it is unrealistic to expect that such data could and should be accessed when families are being worked with through universal services. Child in Need and Child in Need of Protection systems allow for a 'deeper trawl' of information.

4.12. However, there is information that it is important to share within universal services. For instance maternity notes record that at birth Baby Q was found to have an asymptomatic heart murmur and a referral was made to see a paediatrician six weeks later. This was included in the discharge summary which was sent to the GP surgery. The Health Visitor had no knowledge of this heart murmur until it was again diagnosed on 25th February 2016 on Ward 7. The information she had

originally received from the midwives made no mention of this. So, although this review has identified examples of good information sharing, in this instance the Health Visitor was effectively out of the 'communication loop'. Effective information sharing, therefore, is not a linear process, passing data from one place to another, it needs to join up so that all relevant professionals and services have the information they need. As has been referred to in previous Serious Case Reviews, this joining up and triangulation of information can also be affected by the different and separate electronic recording systems within health services with variations in terms of which professionals can access which system.

4.13. Another factor that can affect the flow of information is the circumstances in which it is passed on. In this situation, when the mother and grandmother took Baby Q to the Minor Injuries Unit the decision was to refer the baby to Ward 7. The family were in the room when the MIU practitioner spoke to the Registrar which potentially could have inhibited what was said. Perhaps sometimes it is better to have 'difficult conversations' away from the family in order to alert professional colleagues. Perhaps if the Health Visitor had been able to refer directly to Ward 7 then she might have been able to give more background information and highlight the vulnerability of this baby. In the event the message that the Registrar received was that there were no social concerns and having checked that Baby Q was not subject to a Child Protection Plan, safeguarding concerns were also excluded.

4.14. **Referral pathways to Ward 7:**

When mother brought Baby Q to the clinic on 25th February she reported concerns with the baby's left leg. The Health Visitor contacted Ward 7 as she thought it the most direct way of Baby Q being seen. She was told that the referral pathway was via a GP. The Health Visitor then rang the GP surgery who in turn said they would ring the family. However, she knew that this was a family who often did not pick up the phone, felt this current situation did not warrant an ambulance being called but also was

not confident the family would get to Stoke Mandeville Hospital. So to expedite matters she involved MIU.

4.15. It is unclear why Health Visitors are unable to refer directly to Ward 7 when other health professionals such as midwives, community nurses, advanced nurse practitioners and GPs can. It is clear that referral pathways need to be clarified in order that the welfare of babies and children is not compromised.

4.16. **Routine Enquiry:**

Though routine enquiry regarding domestic abuse was explored at the booking in appointment in June 2016 and was negative, this did not seem to have been reviewed later in the pregnancy. Routine enquiry should normally be revisited at 28 weeks but in this situation mother was seen at clinic at this juncture and therefore by a doctor and not a midwife. Although routine enquiry can be undertaken by any professional within the multi disciplinary team it does tend to become the responsibility of the midwife, with the doctor focussing on medical care. However, the emphasis has to be on the importance of enquiry throughout pregnancy.

4.17. **Maternal mental health issues:**

At the booking in appointment it was noted that mother said she had a history of postnatal depression (PND) after the birth of her son in 2013, but had not required medication. She also talked about a family history of depression specifically with regard to an uncle. The midwife explored this using the Whooley questions[4] with negative results. However, the Health Visitor was not aware of a history of post natal depression and she had had contact with the family since the birth of their first child. As it was the mother who self reported this to the midwife was that her interpretation of how she felt rather than a diagnosis? If indeed she had suffered from PND would that not have been recorded somewhere, as it

[4] The Whooley questions were introduced by the National Institute for Clinical Excellence (NICE 2007). They are a screening tool designed to try to identify two symptoms that may be present in depression.

would have been significant information for the professionals caring for her during subsequent pregnancies?

4.18. In October 2015 the GP surgery received the letter from the DWP health assessment advisory service to say at a recent review mother had talked of having thoughts of jumping out of the window. This was followed up by one of the GPs who booked an appointment for her which she did not attend. Approximately two weeks later mother saw a locum GP because she was feeling down, was lacking energy and had low mood. The GP assessed her as not suicidal and gave her the telephone number for Healthy Minds. This information was not shared but it would have been good practice for the Health Visitor to have been alerted so that she could monitor the situation more closely. However, as has already been discussed in this report, mother's attendance at the surgery was chaotic and she saw a wide range of professionals. In addition at that time, the surgery was experiencing a high turnover of staff all of which affected continuity of care.

4.19. **Triggers and thresholds for referral:**

Was there a point in this situation when referral on to either Early Help or Children's Social Care could have been considered? This family were chaotic and a lot of professional energy went into encouraging and ensuring attendance at appointments. However, they did have support from extended family, there were no indicators which raised concerns about the older children and neither did observations of mother's interactions with Baby Q, apart from the Health Visitor having to advise not to prop the Baby up on a pillow and at a later date the Community Staff Nurse noting that she was not strapped into her buggy.

4.20. Perhaps when the mother missed two appointments for a glucose tolerance test (GTT) this could have triggered a referral to and discussion with the Safeguarding Midwife but it is difficult to say what outcome this would have had. The family were then assessed as vulnerable by the Health Visitor, which was why they were receiving a Universal Plus Health Visiting Service, itself a form of early help.

4.21. The family did not bring Baby Q for her 6 week check and the surgery tried several times to reorganise this. Could this have been a trigger for referral on as missing such a check has been identified as a significant event in previous serious case reviews. However, the visit to Ward 7 then intervened with the consequent plan of action on discharge.

4.22. **Caring for babies and monitoring parents in a hospital setting:** On admission to Stoke Mandeville Hospital in March 2016, examination and x-ray of Baby Q's right leg revealed a fracture that was unexplained and a referral was made to First Response. Mother stayed with Baby Q and a Staff Nurse was allocated to care for the baby. Whilst she was able to keep a close eye and was able to respond to mother's requests it is unrealistic to expect that she could have stayed in the room the whole time as she had other patients to care for. It was later when undressing Baby Q to weigh her that the mark on her arm and disfigurement to that arm was seen. As soon as it was clear that there was more than one injury then contact with all relatives was restricted and supervised.

Good Practice

As well as the issues and difficulties identified it was also recognised that there was good practice in this situation including.

4.23. The Health Visitor was proactive in following things up when appointments were missed and in the ongoing monitoring of the situation through unannounced visits.

4.24. Although some information was not passed to the Health Visitor, on the whole liaison between the Health Visitor and the GP surgery was good, for instance keeping each other informed when appointments were missed.

4.25. There were some excellent examples of sound professional judgements. The Health Visitor, when she could not refer directly to Ward 7, made the decision to send Baby Q and her mother to the MIU as she

did not want any delay and was not confident the family would respond to a phone call from the GP or get themselves to Stoke Mandeville Hospital. At the second hospital admission the Community Staff Nurse spoke directly to the PDU and gave them background information. This meant that when she arrived at the hospital Baby Q bypassed A&E and went straight to paediatrics. Later, on the ward, the Staff Nurse observed that mother had a short attention span and so made the decision to weigh Baby Q when mother had gone out to the shop. The Staff Nurse was not confident that mother would remember that Baby Q needed weighing. This is when the deformity to the arm and the two marks were seen, which led to further x-rays and discovery of fractures in all four limbs.

4.26. At the second hospital admission in March 2016 child protection procedures were triggered promptly and what followed was some very good communication, co-ordination and working together between hospital staff, Children's Social Care and the Police.

5. Conclusions

5.1. This review was undertaken because of multiple unexplained injuries to a 12 week old baby. The parents of Baby Q were young and there were two older siblings under 3 years of age. Both mother and father had moderate learning difficulties and as children, both had statements of special educational needs and attended special schools. As an adult mother presented well initially making it hard to assess her level of understanding and functioning as a parent.

5.2. There were no concerns about the care of the two older siblings but, until March 2015, the family had lived with paternal grandparents who were supportive in the care of the children. Once in their own accommodation they were more difficult to engage with because of things such as missed health appointments, both ante and post natal, a tendency to book GP appointments on the day, not being in for

prearranged visits by health professionals and not always picking up the phone. This made continuity of care difficult to achieve.

5.3. Although the mother described how she and her husband shared the care of the children, the father of Baby Q was seldom seen by, or did not make himself available to health professionals, which meant that there could be no meaningful assessment of his parenting capacity. Mother tended to attend appointments alone or with paternal or maternal grandmother. Lack of professional engagement with fathers has been noted in previous SCRs undertaken in Buckinghamshire and work is ongoing to address this issue.

5.4. The father was known to the Police for matters involving public disorder, theft, arson, robbery and assault but this information was not available to other professionals involved with Baby Q. Similarly there are indications that mother had some mental health issues, including saying she had had PND after the birth of her eldest child. However, this information seemed to be neither recorded at that time nor shared with the Health Visitor in the period under review.

5.5. This family were, however, assessed as vulnerable and Baby Q's poor weight gain and faltering growth led to professionals working hard to engage with the family, to see and monitor the baby and to respond promptly when concerns were identified.

6. Recommendations

6.1. In this situation the Health Visitor was unable to refer directly to Ward 7 and so to expedite matters involved the MIU. It is therefore recommended that referral pathways to Ward 7 are clarified to ensure that all children and babies are seen promptly when the need arises.

6.2. Routine Enquiry regarding domestic abuse was undertaken at the booking in appointment and was negative but this was not reviewed later

in the pregnancy. It is recommended that midwives, health visitors and obstetricians are reminded of the importance of undertaking routine enquiry and equipped with the skills to do so. It is acknowledged that work has already begun in this area as a consequence of the recommendation of a previous Serious Case Review, but this work needs to be broadened out and developed further to include all health professionals in contact with a family.

6.3. The problems in assessing parenting capacity when parents have learning difficulties and in working with families who are difficult to engage because of those learning difficulties are two interlinked themes which have emerged from this review. It is recommended, therefore, that BSCB work jointly with BSAB to look at these issues. It is suggested that a specialist working group be established to:

- Scope the extent of the problem.
- Identify what supports are already available.
- Identify the gaps in Early Help Services
- Make recommendations about what could be developed.

6.4. Work has already begun on pulling together, analysing and disseminating the learning from recent SCRs in Buckinghamshire concerning babies. It is recommended that this work is further developed in the light of the learning from this review and a programme of seminars rolled out across the county to highlight key messages and their implications for practice.

Rec No	Recommendation from Individual Management Review	Action/s to be taken to fulfil recommendation	Person(s) responsible (include job title)	Timescale for implementation (please be as precise as possible)	Intended Outcome	How will we know? (what evidence is there to show that the action has been completed successfully?)	Update provided by	RAG rating
1	In this situation the Health Visitor was unable to refer directly to Ward 7 and so to expedite matters involved the MIU. It is therefore recommended that referral pathways to Ward 7 are clarified to ensure that all children and babies are seen promptly when the need arises.	Review of Paediatric Referral Pathway for under 1 year olds to show who can refer and where (including MIIU and Ward 7)	• Audrey Warren (BHT) - Midwives • Vicky Peploe (BHT) - Health Visitors	End of May 2017	Children will receive appropriate and swift treatment on presentation	Production and implementation of reviewed Paediatric Referral Pathway		
		Audit of reviewed pathway		End of July 2017				
		Re-audit of reviewed pathway		End of May 2018				
2	Routine Enquiry regarding domestic abuse was undertaken at the booking in appointment and was negative but this was not reviewed later in the pregnancy. It is recommended that midwives, health visitors and obstetricians are reminded of the importance of undertaking routine enquiry and equipped with the skills to do so. It is acknowledged that work has already begun in this area as a consequence of the recommendation of a previous Serious Case Review, but this work needs to be broadened out and developed further to include all health professionals in contact with a family.	Audit of Routine Enquiry to see if question being asked 3 times	• Heidi Beddall (BHT) • Jenny Chapman (BHT) • Dr Mishra (BHT) - Obstetricians Overseen by Audrey Warren (BHT)	Results of audit by end May 2017	All health visitors, Midwives and Obstetricians are aware of Routine Enquiry pathway	Results of Audit/s		
		Re-embedding of pathway (if necessary)		Re-embedding of pathway by end July 2017				
		Re audit of Routine Enquiry		Re-audit by end May 2018				
3	The problems in assessing parenting capacity when parents have learning difficulties and in working with families who are difficult to engage because of those learning difficulties are two interlinked themes which have emerged from this review. It is recommended, therefore, that BSCB work jointly with BSAB to look at these issues. It is suggested that a specialist working group be established to: • Scope the extent of the problem • Identify what supports are already available • Identify the gaps in Early Help Services • Make recommendations about what could be developed	Initial meeting between BSCB Business Managers and TA (SCR Panel member) to establish membership and remit of specialist working group	• BSCB Business Manager (Matilda Moss) • BSAB Business Manager (Nicky Barry) • SCR Panel Member (Tania Atcheson)	ASAP	Parents with learning difficulties will be identified and effective support will be made available at an early stage Increased recognition by practitioners of issues parents with learning difficulties face Increased practitioner confidence when working with parents who have learning difficulties	Report shared with all partner organisations so that they can benefit from the learning		
		Specialist working group to be established to look at recommendation	As agreed at initial meeting	July / Aug 2017				
		Report presented to BSCB and BSAB	• BSCB Business Manager (Matilda Moss) • BSAB Business Manager (Nicky Barry) • Chair of specialist	Jan / Feb 2018 (actual date of Board meetings unknown at present time)				

4	Work has already begun on pulling together, analysing and disseminating the learning from recent SCRs in Buckinghamshire concerning babies. It is recommended that this work is further developed in the light of the learning from this review and a programme of seminars rolled out across the county to highlight key messages and their implications for practice.	To extend remit of current SCR Learning sessions to include parents with learning difficulties	• BSCB Training Manager (Ann McKenzie) • L&D Sub Group	July 2017	Current SCR learning sessions will include section on parents with learning difficulties	Copy of presentation		
		To develop methods of disseminating learning to a wider audience		December 2017	SCR learning available in easily accessible formats (podcasts? - on BSCB website)	Number of hits on BSCB website		