Overview Report

of the

SERIOUS CASE REVIEW

relating to

Child BB

Arthur Wing
March 2017

CONTENTS

1. INTRODUCTION

1.1. In late May 2014, the child BB was taken to hospital in a state of extreme physical collapse. It was noted that BB had a large bruise to the side of the head and other bruise and burn marks. BB was transferred to a hospital with a paediatric intensive care unit later that day and died there the next day.

1.2. There is a legal requirement, as defined in Statutory Guidance, Working Together to Safeguard Children 2013[1], to undertake a serious case review when abuse or neglect of a child is known or suspected and

- either a child has died,
- or a child has been seriously injured and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

1.3. This matter was referred to the Local Safeguarding Children Board in Surrey where child BB had been living. In June 2014, the Strategic Case Review Group (SCRG) of the Surrey Safeguarding Children Board (SSCB) met to consider whether the criteria for a Serious Case Review were met. It noted that BB had only been known to universal services and that there had been limited contact with BB and family. Having considered the circumstances and taken the advice of the National Panel of Independent Experts on Serious Case Reviews, the Chair of the SSCB determined, in August 2014, that it would carry out a review. It was noted that the National Panel had advised that the review should be proportionate.

1.4. The purpose of a Serious Case Review, as set out in the Statutory Guidance, Working Together 2013, is to identify improvements which are needed and to consolidate good practice in order to prevent similar deaths or serious injury.

[1] Working Together to Safeguard Children, HMSO, 2013, since superseded by Working Together to Safeguard Children, HMSO, 2015

2. ARRANGEMENTS FOR THE SERIOUS CASE REVIEW

2.1. The SSCB decided that its Strategic Case Review Group would be the reference group for this review. It was chaired by Alex Walters, the Independent Chair of the Board at the time. Its function was to manage and oversee the conduct of the review. The membership of the SCRG is set out at Appendix 1. The Board appointed an independent reviewer, Arthur Wing, to lead the review and to write this overview report. He was assisted by Amanda Quincey, SSCB Partnership Support Manager.

2.2. Internal management reviews (IMRs) were submitted in November 2014. In total, six IMRs were requested from the following agencies which had had contact with child BB and the family:

- Health Care Provider of hospital services
- Health Care Provider of mental health services and community alcohol and drug services
- Health Care Provider of community services providing health visiting, school nursing, and speech and language therapy services
- Surrey Police
- Bedfordshire Police (IMR subsequently updated)
- Bedfordshire Probation Trust. The IMR was provided by the National Probation Service – Bedfordshire as Bedfordshire Probation Service ceased to exist in 2014.

2.3. In addition, written information was provided by agencies with less significant or less recent information:

- Local Clinical Commissioning Group (Surrey general practitioners)
- Surrey County Council Schools and Learning
- Health Care Provider of Paediatric Intensive Care Unit
- Local Housing Department
- Luton Safeguarding Children Board on behalf of Luton, Bedford Borough and Central Bedfordshire Children's Services
- Metropolitan Police

The report of the Consultant Paediatric Pathologist who examined BB was also considered.

2.4. This report was written in anticipation that it will be published. Consequently, the information in the report is limited so as to:

a) take reasonable precautions not to disclose the identity of the child or family
b) protect the right to an appropriate degree of privacy of family members

The health services involved and the local borough council are anonymised in order to avoid revealing in which part of the county the family live.

2.5. Terms of Reference for this SCR are at Appendix 2. The child BB was the main subject of the review and its principal focus was from June 2012 (when BB was born)

until June 2014. All agencies were, however, asked to provide a summary of all significant events and relevant family history outside the specific timescale where this would inform the overall analysis.

2.6. All internal management reviews addressed the terms of reference. All the authors of the internal reviews were independent of the case and its management, and all bar one conducted interviews with staff involved with child BB and the family. Seven members of staff were interviewed in total.

2.7. Following consideration of the combined chronology of events and the internal reviews, the independent reviewer met with BB's father. He provided helpful information as well as his perspective on what had happened. It is recognised that this hasn't all been corroborated.

2.8. It was not possible to interview either BB's mother or the mother's partner or the maternal grandparents at this stage as criminal proceedings were continuing.

2.9. In February 2015, after the first draft of this report had been compiled, the independent reviewer met with the Strategic Case Review Group. It was agreed that a report would be requested from Luton, Bedford Borough and Central Bedfordshire Children's Services Departments. Luton Safeguarding Children Board agreed to coordinate their responses. This report was received in May 2015 and a second draft of the Interim Overview Report was considered by the Strategic Case Review Group in June 2015. The Group commented on the findings and recommendations and agreed that the Interim Report should be considered by the Surrey Safeguarding Children Board in July 2015.

2.10. Following this meeting, the Interim Report was circulated to the agencies confirmed to enable them to check its accuracy. Minor changes were then made. It was decided that the Report should not be published as there were ongoing criminal proceedings. Key aspects of the learning from the Review were however published in November 2015.

2.11. BB's mother and her partner were sent for trial at Crown Court charged with two offences: causing or allowing the death of a child and causing or allowing a child to suffer serious physical harm. Shortly before the original date for the trial, the mother's partner committed suicide. BB's mother was tried and found Not Guilty of both charges.

2.12. The Interim Report was then shared with both BB's mother and BB's father. Their comments have been taken into account in the preparation of this, final, version of the report.

2.13. The completion of the report was initially delayed pending the possible holding of an inquest. In early 2017, it was determined that an inquest would not be held. The Overview Report was considered and accepted by the Surrey Safeguarding Children Board.

3. METHODOLOGY

3.1 The review process has been conducted in line with the agreed Terms of Reference and has taken account of the principles set out in Working Together 2013. It has aimed to contribute to learning and improvement through consolidating good practice and identifying where practice can be improved and to recognise the complexity of safeguarding children and to seek to understand not only what happened but why individuals and organisations acted as they did.

3.2 The principles as set out in Working Together are:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice.
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Families, including surviving children, should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring that the child is at the centre of the process.
- Final reports of SCRs must be published, including the LSCB's response to the review findings, in order to achieve transparency**.** The impact of SCRs and other reviews on improving services to children and families and on reducing the incidence of deaths or serious harm to children must also be described in LSCB annual reports and will inform inspections.

4. SUMMARY CHRONOLOGY

4.1. BB was born in June 2012, weighing 3.044 kg, which is in the 25th percentile. It was a normal birth at the local hospital. No concerns were noted and mother and baby were discharged home the following day.

4.2. There were routine visits by the health visiting service and it was noted that BB gained weight during the next two weeks. BB was subsequently taken to the clinic for immunisations.

4.3. In the summer of 2013, BB's mother moved home and for a while the health visitors weren't aware of her address. Contact was resumed in February 2014. In March 2014, BB was taken to the local Paediatric Accident and Emergency Department, suffering from viral gastroenteritis. In May 2014, it is recorded that BB was seen by the GP. BB presented with polyuria and polydipsia (excessive drinking and urination). The records state that BB was well throughout and happy and very active. BB's mother was asked to bring in a urine sample but did not do so. This was less than two weeks before BB died.

4.4. BB was brought to the local hospital's Paediatric Accident and Emergency Department in late May 2014. This is recorded as being at 2.52pm and by mother. BB was noted to be in a state of extreme physical collapse and with bruises, scratches and burn marks. The possibility of non-accidental injury was raised as a concern. Appropriate procedures were followed and a strategy meeting was held. Following examination and a CT scan, BB was transferred to the hospital with a Paediatric Intensive Care Unit, about twenty miles away. On arrival at this Unit, it was noted that BB was very unwell and in a critical condition. Although given full support to vital systems, BB died the following afternoon.

4.5. It was noted that BB's mother was joined at the local hospital by her partner and her grandmother and then at the second hospital by BB's father.

4.6. The history given to the review by BB's mother was that she had put BB to bed and gone out to work in the early hours of the morning, leaving BB asleep and her partner to care for her. She had returned at about 10.30am. Her partner told her that BB had woken early but was asleep again. She went to bed herself and was later woken by her partner who said that BB was still sleeping. She found BB limp and not responsive and so took BB to hospital. She stated that she changed BB before leaving for the hospital. It is recorded that when she was asked why she didn't call an ambulance she gave no explanation. She has subsequently explained that she lived near the hospital and had previous experience that it was quicker to get there by car.

4.7. When asked at the hospital about the other marks on the BB's body, BB's mother said that what appeared to be burn marks on the trunk had been caused by a hairdryer. This happened when BB was sat on her lap while she dried BB's hair. Her partner told the staff in the first Paediatric Accident and Emergency Department that the bruise on BB's forehead was caused by the shower head falling while he was bathing BB a couple of days earlier. The Ambulance Network staff who conveyed BB

between the two hospitals said they had been told that the bump to the head had happened two days earlier in a fall in the garden. BB's mother has said to the author that these accounts were not accurate but that she did not know how or when the injuries were caused.

4.8. It is noted that the pathologist considered that it was unlikely that the burns had been caused accidentally, that the severity of the head injury was in excess of that which might be due to a shower head falling on the child and that the extent of the injury would be incompatible with other than a very short survival following infliction.

5. THE FAMILY

5.1 *BB's Mother*

5.1.1 BB's mother was 24 years old when BB died. She had been brought up locally and received a normal secondary education. It is understood that she had some contact with the Child and Adolescent Mental Health Service which was linked to her having witnessed domestic violence as a child as well as having been the victim of some parental violence. It is recorded that she suffered from depression and self-harming.

5.1.2 She was referred to the local Community Mental Health Team in 2009 as she was experiencing depression and mood swings and had taken an overdose. She was assessed, asked to consider taking anti-depressant medication and referred for psychotherapy. She did not attend for a follow-up appointment or for a psychotherapy appointment.

5.1.3 BB's mother attended for ante-natal appointments at which her history of depression was discussed. This was then picked up by health visitors during their post-natal visits. In view of her history of depression, a specific mood assessment was carried out on July 2012 and no concerns were identified or raised by BB's mother.

5.1.4 In June 2013, BB's mother, who had been living in privately rented property, moved to another part of Surrey. The move meant that she was living nearer her parents.

5.1.5 BB's mother was in work and regularly used her parents to care for BB. It was, for example, recorded by the health visitor that in February 2014 she was on a course and her step-father was looking after BB. It is also recorded that at the time of BB's death she was working as an airport security guard.

5.1.6 BB's mother has stated that she was not aware that her new partner (Mr Y) had a history of domestic violence or allegations of assaults on children. He appeared to be good with BB and she considered that he seemed used to helping with young children which was consistent with the partial history he had given her.

5.2 *BB's Father*

5.2.1 BB's father was 33 years old when BB died. He lives in London.

5.2.2 He explained that he had met BB's mother through an internet dating site – "PlentyofFish".

5.2.3 He explained that the two of them had never lived together but that he remained in contact with her because of BB. He stayed with her for the first few days after BB's birth and then travelled back and forth regularly during the first month. In order to be sure that he was BB's father, they arranged their own DNA test.

5.2.4 There was no arrangement for him to pay maintenance but he contributed when he was working. There was also no formal agreement about his contact with BB. It developed into an arrangement whereby he would see BB for the day every other week. He would take BB out locally and then sometimes to visit his family and, latterly, to his current girlfriend's.

5.2.5 He had last had contact with BB on 17 May 2014, the day of the FA Cup Final. He did not have any concerns about BB that day; he thought BB was happy although he did comment that BB had eaten more than usual.

5.2.6 He was alerted to BB's admission to hospital as BB's mother had called his sister. He travelled to the hospital and was in transit when diverted to the specialist hospital.

5.2.7 He had not been aware of any injuries to BB. He was not aware of any concerns about BB having been shared with statutory or voluntary agencies. He commented that BB's mother had always taken BB to the doctor's promptly when unwell which made the report that BB had suffered injuries in the days before her death and yet wasn't taken to the doctor's or the hospital unexpected.

5.2.8 He had been aware that there was a man in BB's mother's life as he had seen a photo of him kissing BB, something which had concerned him and that he had taken up with BB's mother. He said that he did not know how they met or anything about him. He did, though, say that, a short while before BB's death, BB's mother had told him that in future he should communicate with her by email and not phone or text.

5.3 BB's Grandparents

5.3.1 BB's mother's parents lived nearby. It is understood that they were actually BB's mother's mother and her step-father, although he had been part of her life from the time she was a baby. It is understood that she was working but that he didn't following an injury at work. It is known that when BB's mother was at work or on a course he provided some care for BB but the details of this aren't known.

5.4 BB's Mother's Partner (Mr Y)

5.4.1 Mr Y was 35 years old when BB died. It is understood that he and BB's mother met through an internet dating site in early 2014 and that by the time that BB died he was living with her. Following his arrest, he was prevented from having contact with her through his, and her, bail conditions.

5.4.2 It is understood that he had two sons, one born in 2003 and the other (with the victim of the offence referred to in paragraph 5.4.3 below) born in 2009.

5.4.3 He was previously living in Bedfordshire, where he was known to various statutory services. He had a history of domestic violence and had served a prison sentence for assault (on a stranger) in 2006. For his 3rd conviction for domestic violence, the common assault of his girlfriend, he was placed on a Community Order for 2 years with requirements of supervision and attendance at a domestic violence programme.

5.4.4 He did not complete the domestic violence programme and it was replaced with an unpaid work requirement. He completed this and his supervision requirement in 2013. As he was under supervision, there are probation records available about this time (see paragraph 6.11 below) as well as police and children's services records (see paragraphs 6.10 and 6.7).

5.4.5 From these records it is clear that he had a number of relationships with women who had children and that there had been a number of incidents when police or children's

services had been alerted to concerns about these children (described in paragraph 6.10).

5.4.6 There are known to have been two further agency contacts with Mr Y in Bedfordshire in 2014. In the first, Bedfordshire Police were called to a domestic violence incident in Luton on 5 April 2014 in which a woman said he was still harassing her and that their relationship had ended a month previously.

5.4.7 In the second, on 26 April 2014, he was arrested by the Metropolitan Police, in Bedfordshire, in relation to the sending of a malicious communication to his cousin's then girlfriend on 26 March 2014. He was prosecuted for this and, on 18 February 2015, a Restraining Order was made and he was sentenced to a Community Order with an Unpaid Work Requirement.

6 THE AGENCIES WHO CONTRIBUTED INFORMATION TO THIS REVIEW

6.1 Health Care Provider of hospital services in Surrey

6.1.1 The hospital had contact with BB and mother at the time of BB's birth in 2012. This included BB's mother's disclosure of her earlier episode of depression. The midwife discussed this with her and, with the mother's agreement, made a referral to the Health Visiting Service.

6.1.2 There was a further contact on 19 March 2014, when BB was referred by a G.P. at a local Walk In Centre to the Paediatric Accident and Emergency Department, suffering from viral gastroenteritis. The record of this presentation shows that a holistic assessment of BB's presentation, birth, past and present medical history was considered. It was noted that BB was living with mother, who was receiving support from her family. It is reported that no details of BB's father or any male partner are recorded but that it is noted that BB's parents were no longer in a relationship.

6.1.3 The next contact was at the end of May 2014, when BB was brought to the Paediatric Accident and Emergency Department by BB's mother. During examination, multiple bruise and burn marks were noted and the possibility of non-accidental injury was raised as a concern. Efforts were made to stabilise BB's condition and following a CT Scan, BB was transferred to the appropriate hospital providing a Paediatric Intensive Care Unit. In parallel, actions were taken in relation to safeguarding. Children's Services were contacted and a strategy meeting was held later that day.

6.2 Health Care Provider of mental health services in Surrey

6.2.1 This provider reported on its contact with BB's mother in 2009, as described in paragraph 5.1.2 above.

6.3 Health Care Provider of community services providing health visiting, school nursing, and speech and language therapy services in Surrey

6.3.1 This provider gave comprehensive details of the contacts that health visitors had had with BB and mother. Following assessment, no safeguarding concerns were identified and the family was placed in the core, or universal, service. There is no information that suggests that this wasn't an appropriate decision.

6.3.2 As has been noted in paragraph 5.1.3 above, a mood assessment was carried out in the light of BB's mother's disclosure of her history of depression. She expressed no mental or emotional health issues at that time and it was also noted that the attachment observed between mother and child was good and that she was able to meet all her child's needs and had good support from her partner (BB's father) and her family.

6.3.3 Records indicate that BB was taken to appropriate clinics in early 2013 but was not taken to an optional one year developmental screening. In September 2013, the health visiting service received a report that BB had been taken to a Walk In Centre with constipation. This indicated that the family had moved and the health visitor made considerable efforts to confirm this in order to transfer them to the local team. Ultimately these efforts were successful and telephone contact with BB's mother was

made in February 2014. When asked by the health visitor, BB's mother said she had no concerns about BB's general health.

6.4 Surrey General Practitioners

6.4.1 A review of records shows that BB was registered with a G.P. There were no recorded non-attendances and BB was repeatedly referred to as a "happy, well and active child".

6.4.2 The records refer to the attendance at the Paediatric Accident and Emergency Department on 19 March 2014 referred to in paragraphs 4.3 and 6.1.2 above and to the attendance in mid-May 2014, referred to paragraph 4.3 above. On this latter occasion, BB presented with polydipsia and polyuria (excessive drinking and urination). The records state that BB was well throughout and happy and very active. There is no record of an examination. BB's mother was asked to bring in a urine sample but had not done so by the time BB died.

6.5 Surrey County Council Schools and Learning

6.5.1 This service confirmed details of BB's mother's education. There is also reference to BB in an Early Years database but without any additional information.

6.6 Health Care Provider of Paediatric Intensive Care Unit

6.6.1 This hospital only had contact when BB was admitted and died at the end of May 2014. Its report gives details of BB's presentation on admission, the assessments carried out and the treatment given.

6.6.2 The history taken has been summarised in paragraphs 4.6 and 4.7 above.

6.6.3 Staff at the hospital were aware of the safeguarding concerns and recorded them on the relevant form.

6.7 Luton Safeguarding Children's Board - on behalf of Luton, Bedford Borough and Central Bedfordshire Safeguarding Children Boards

6.7.1 This report established that none of the three Bedfordshire Children's Services had any contact with Mr Y at the time he is likely to have met BB's mother nor at the time of BB's death. They were not therefore in a position to alert Surrey agencies to his presence. Their reports indicate that although Mr Y had been named in connection with a number of allegations, as described in paragraph 6.10 below, they had not had any direct contact with him at those times.

6.8 Local Housing Department

6.8.1 The local housing department had had minimal contact with BB's mother. She contacted them when she was pregnant. She was living with her parents at the time and subsequently found her own accommodation.

6.9 Surrey Police

6.9.1 Surrey Police have reviewed their records. They had no contact with the family prior to BB's final admission to hospital.

6.10 Bedfordshire Police

6.10.1 BB's mother's partner, Mr Y, was well known to Bedfordshire Police as described in paragraph 5.4 above.

6.10.2 Following the making of his Community Order on 11 August 2011, a number of incidents were recorded. It is noted that the victim of the common assault that led to this order had been the subject of a number of domestic related incidents and obtained a non-molestation order against Mr Y in January 2012. There was a report a short time later that he was attempting to gain entry to her house. When police attended, she stated that nothing had happened.

6.10.3 In May 2012, August 2012 and October 2012, there were incidents relating to a family in Bedford. The police investigated allegations of assaults on children in May and October 2012 and an alleged incident of domestic violence in August 2012. The children were aged twelve and four respectively. The allegations implicated Mr Y but, in the case of the assaults, the child's mother or the child gave a different explanation and in the case of the domestic violence incident, no-one in the home made a complaint when the police attended. The first two incidents were reported to the local children's services while the third incident had been referred to the police by them. On each occasion, no further police action was taken.

6.10.4 In April 2013, the police investigated an allegation of an assault on a six year old child in Luton. Mr Y was interviewed but the child's mother corroborated his account of what had happened. The local children's services were made aware of the incidents and no further police action was taken.

6.10.5 It is recognised that in themselves these incidents and alleged assaults were not the most serious. Two of the complaints had also come from the mothers' ex-partners. A common feature of these incidents was however that, while the relevant children's services were informed about them, the probation service wasn't even though Mr Y was under supervision for assault in a domestic situation. This was unfortunate as, if these links had been made, then the pattern of incidents could have been identified and consideration given to how Mr Y's behaviour could be addressed.

6.10.6 In April 2014, the Bedfordshire Police received a report from a woman living in Luton that Mr Y had been sending her threatening messages following their separation a month previously. She was visited but it was concluded that no offence had been committed. The Bedfordshire Police IMR writer considers that this incident could have been further investigated and reviewed.

6.10.7 Mr Y was also stopped or questioned by the police about three other matters. Of most significance was that in May 2013, he was questioned about an alleged sexual assault on a female. Forensic examinations and identification procedures did not identify Mr Y and, following evidence that the victim might have made the story up,

no further action was taken. The Probation Service record does not refer to this incident.

6.11 Bedfordshire Probation Trust

6.11.1 As stated in paragraph 5.4.3 above, for his third conviction for domestic violence, the common assault of his girlfriend, in August 2011, Mr Y was placed on a Community Order for 2 years with requirements of supervision and attendance at a domestic violence programme. This order was managed by the then Bedfordshire Probation Trust. He was assessed as posing a Medium Risk of Serious Harm[2] to a known adult (his previous partner), his two children when in contact, future intimate partners (plus their children) and the public (he had a previous conviction for assaulting a stranger).

6.11.2 He only attended the domestic violence programme a few times and was taken back to court in May 2012 for failing to comply with the court order. He showed little motivation and was re-assessed as being unsuitable for the programme. An Unpaid Work Requirement was made instead. He was again taken to court in June 2012 for failing to comply with the requirements to attend for supervision and unpaid work. Following adjournments, he was ordered to carry out additional hours of Unpaid Work. He completed his order in November 2013.

6.11.3 The probation review noted that there had only been one check with the police to see if there had been any call-outs to his original victim's home – there had been none.

6.11.4 In November 2012, it is recorded that Mr Y wanted to resume contact with his son. His son's mother had been the victim of the offence for which he was under supervision. It would seem that he was successful as he subsequently reported having contact with his son, although later, in May 2013, he reported that his son's mother had stopped his contact.

6.11.5 In March 2012 and April 2013 he told his probation officer that he was in new relationships with women who had children. He provided little information about them. On the latter occasion, he said that there had been an accusation against him of assaulting her child but that no action had been taken. This was not followed up by the probation officer. The reports to this review indicate that this was the incident described in 6.10.4 above.

6.12 Metropolitan Police

6.12.1 In April 2014, the Metropolitan Police arrested Mr Y. He was interviewed in Bedfordshire and the investigating officer was unaware that he was in a relationship with anyone in Surrey. He was charged with the sending of a malicious communication to his cousin's then girlfriend on 26 March 2014 and convicted of this as detailed in paragraph 5.4.7 above.

[2] The definition of medium risk is "that there are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances for example failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse".

7 FINDINGS

7.1 **The Terms of Reference** laid out a series of critical questions, which are addressed below:

1. Did agencies communicate effectively and work together to safeguard and promote the child's welfare?

No concerns were raised about BB's safety or welfare prior to the final admission to hospital at the end of May 2014.

The review from the Health Care Provider of the Paediatric Intensive Care Unit has identified a number of improvements that could be made in relation to communication and the recording of it. This information is critical both to the medical processes and to the assessment of how the injuries occurred, e.g. how, where, when. On this occasion, there were two recorded explanations of the bruising to the child's forehead – from a shower head and, alternatively, in the garden.

In addition, there needs to be an expectation of a record of who was with the child in hospital in these circumstances, and when, and also of any phone calls made. Although there is no suggestion that in this case, everything wasn't managed well, it can be helpful to have more details about these matters, including any disagreements between relatives about the cause of the injuries.

That provider has made a recommendation for action by that Trust (see paragraph 9.2.2).

2. Was the level and extent of agency engagement and intervention with the family appropriate? In view of the difficulties that Health Services had in contacting the mother, were assessments undertaken in a timely manner, was the quality adequate and did they include fathers, extended family and all historical information?

BB was appropriately placed in the "Universal" health visiting service. There was a period when BB's mother had moved and they were out of contact with services. They would seem to have moved between the end of May 2013 and September 2013. During this period, BB was not taken for a one year developmental assessment, although this is described as optional. The first knowledge of the move was when BB was taken to a Walk In Centre near the family's new address in September 2013. The health visitor attempted to contact BB's mother to establish if she had moved and the records should be transferred to the local health visiting team. In February 2014, the Health Visitor made contact with the GP's surgery and found they still had the old address. The efforts to contact BB's mother were successful and she was contacted by phone. In February 2014, she registered BB at a G.P.'s surgery near her new address.

Although the efforts made to contact BB's mother were commendable it would have been good practice to have carried out a home visit rather than assessing the situation over the phone.

3. Was any information known by any agency about parental mental health issues, domestic abuse, substance misuse or parental antisocial behaviours or concerns re neglect? If so was appropriate consideration given to how these impacted on parenting capacity and were appropriate referrals made?

BB's mother had disclosed her history of depression to her midwife. This was then passed on to the health visiting team. The review of the midwifery involvement comments that there was some limited consideration of whether this should lead to a referral to a specialist provider. The history of depression was notified to the health visiting service although this referral could have been recorded more clearly.

The history of depression was then considered by the health visitor who conducted a mood assessment.

4. What information was known by agencies about the wider family in particular BB's father, mother's partner - Mr Y, maternal grandparents and maternal great grandparents who were all involved in BB's care?

No significant information was held on BB's record about any of these adults. There was a minimum of information recorded about BB's father at the time of BB's birth. There was no record of BB's mother being asked why she had moved. It was though noted by the health visiting service that BB's grandfather was looking after BB while mother was on a course.

No Surrey agencies held any information about Mr Y nor did any of the agencies dealing with BB know of his relationship with the family prior to the final hospital admission. Information about him was held by agencies in Bedfordshire - Children's Services, Police and Probation, although they did not know that he had moved to Surrey or that he was in a relationship with BB's mother.

5. Did Bedfordshire Probation Service know that Mr Y was living in Surrey and in a relationship which enabled contact with Children?

Bedfordshire Probation Trust had no knowledge that Mr Y was living in Surrey or that he was in a relationship with BB's mother. Their last contact with him, apart from a phone call from him to an administrator on 4 December 2013, was on 16 October 2013. From BB's mothers account, she only met Mr Y after his contact with the probation service had ended.

6. ***Was there sufficient consideration of the vulnerability of this family in relation to their housing situation and the impact on their parenting capacity and what support was provided?***

   Although BB's mother contacted the local housing department when pregnant, she then found her own accommodation. There was no suggestion that she was vulnerable in housing terms.

7. ***Were the children's views and wishes sought and taken account of in assessments and planning? Did this include the presentation of these young non-verbal children being fully considered?***

   The agency reports state that BB's non-verbal communications were considered appropriately when BB was examined at different times.

8. ***Were any safeguarding issues in respect of BB identified and acted on appropriately and in a timely way by all agencies?***

   The review by the provider of hospital services in Surrey confirms that safeguarding issues were taken into account when BB presented at the Paediatric Accident and Emergency Department. They were then taken very specifically into account when BB was admitted to the Paediatric Intensive Care Unit and assessed and treated there.

9. ***Were missed appointments and failure to engage considered as indicators of neglect?***

   BB's mother did not miss any specific health or other appointments. The efforts to re-engage with her were to establish where she lived and there had been no suggestion of neglect.

10. ***Was race, religion, language, culture, ethnicity or disability a factor in this case and was it considered fully and acted on if required? How was the uniqueness of this particular family recognised?***

    The ethnicity of BB's parents was recorded at birth. That BB's mother was white and BB's father was black does not appear to have ever been an issue within the family or with agencies. BB's father has confirmed that this was the case.

    Mr Y is also black and there is no information as to whether this has any significance.

11. ***Were there any organisational or resource factors which may have impacted on practice in this case?***

    None have been identified that impacted significantly on the case.

12. ***Were appropriate management/clinical oversight (supervision) arrangements in place for professionals making judgments in this case?***

    Appropriate management, clinical and supervision arrangements were in place in the various agencies.

It is noted that BB's first health visitor was a student health visitor. She was sufficiently experienced for the tasks she performed and her work was overseen and supervised appropriately.

The Bedfordshire Probation Trust review identifies that it would have been helpful if a manager had reviewed the assessments of Mr Y in order to provide a fresh perspective and also if a manager had been consulted in relation to a large number of absences which were authorised as being for acceptable reasons.

Bedfordshire Police have acknowledged that two of the decisions to take no action were open to question and management oversight of them might have been beneficial.

7.2 Summary of Findings in relation to work in Surrey

7.2.1 BB's mother received an appropriate level of midwifery service. She admitted to a history of depression and this was then shared with the health visiting service, who carried out a mood assessment. BB was dealt with by health visitors within the "Universal Service" which was appropriate given the information known. The family lived in privately rented accommodation and, according to all the reports, made only routine contacts with the various statutory agencies.

7.2.2 BB's father has said that, BB's mother would, if anything, seek medical help more quickly than was really necessary. The break in contact with services when she moved was disappointing but there is no evidence that this was for any concerning or neglectful reason.

7.2.3 The agencies did not make detailed records about the family and extended family. Although this would have been helpful to this review there is no evidence to suggest that it should have been a priority at the time.

7.2.4 There was also no information about BB's mother's new partner. Even if this could have been obtained at the Walk In Clinic or hospital in April 2014, this would not have led to any background checks on him unless BB's mother raised any concerns or something untoward was observed.

7.3 Summary of findings in relation to work in Bedfordshire

7.3.1 Several agencies in Bedfordshire were aware of Mr Y and his behaviour. None, however, were aware of his relationship with BB's mother and so none were in a position to alert her to his previous behaviour or to alert their Surrey counterparts.

7.3.2 Two of the three Children's Services in Bedfordshire had dealings with, or received referrals about, families with which Mr Y had been in relationships following allegations made about his behaviour between May 2012 and April 2013. It would appear that there was, though, no direct contact with him.

7.3.3 The Bedfordshire Probation Trust managed Mr Y between 2011 and 2013. Its review comments on a number of aspects of his management. These include the way in which his case was reviewed by his probation officer, the decisions about authorising some of his absences as acceptable and that there should have been

action to check on his behaviour with the police and to liaise with children's services about his new relationships where children were involved. It is noted that he did not provide detailed information about them and that he had a tendency to talk enthusiastically about a new relationship only to say afterwards that it was over. The Probation review also commented that a data cleansing exercise had meant that some records that could have been useful were no longer available.

7.3.5 The Bedfordshire Police review commented on the three allegations of ill treatment directly towards children. In two of them the allegation was made by the child's father and was that Mr Y had caused the injuries while staying at the child's address. On both occasions the mother explained the injuries, clearing him of any blame. Following another incident, the order of questioning was such that it could have assisted Mr Y in clearing himself.

7.3.6 While the police officers made referrals to children's services, they did not liaise with the probation service. They should have noted that Mr Y was on a Community Order and done so, particularly in view of the nature of the allegations. Doing so, and considering his record in more detail, would have enabled them to make a more informed risk assessment and decision in relation to the various incidents.

7.3.7 While it is recognised that each of the recorded incidents in Bedfordshire was relatively minor, the pattern of frequent alleged incidents of domestic violence and assaults on children is a matter of concern even if no complaint was made or the various incidents explained away.

8. KEY ISSUES

8.1 The Police Investigation

8.1.1 Following the conclusion of the police investigation into BB's death, in March 2015 BB's mother and her partner, Mr Y, were charged with Causing or Allowing the Death of a Child and Causing or Allowing the Serious Physical Harm to a Child. In July 2015, shortly before the date of the trial, Mr Y committed suicide. The trial was postponed until January 2016. It resulted in BB's mother being found Not Guilty. In March 2017, it was determined that an inquest would not be held. There is therefore no finding as to how BB might have suffered the fatal injuries.

8.2 Could BB have been protected more?

8.2.1 What is clear from the information available to this review, is that, when the various statutory agencies were working with BB and BB's mother, they did so appropriately and that BB appeared to be well cared for and no concern was raised. Any weaknesses identified in agency practices through the majority of BB's life were therefore not significant in terms of BB's protection and welfare.

8.2.2 BB's father has said that he did not notice any injuries when he was looking after BB on 17 May 2014 and there is no record of any being noticed in March 2014 or 19 May 2014 at the Walk In Clinic and hospital and at the G.P.'s Surgery respectively. It is also understood that BB's maternal grandparents didn't see any injuries when caring for BB on or about 20 May 2014. It therefore seems that the injuries were not evident at the time of the visit to the G.P.'s Surgery on 19 May 2014.

8.2.3 BB's mother has said that she was not aware of My Y's background and previous behaviour with women and children. She had no mutual friends as he came from a different area. At the time, she had no reason to suspect that he was a risk to her daughter. She would say that he was a persuasive and manipulative character.

8.3 Could Mr Y have been managed better and thus kept away from BB?

8.3.1 It is clear that there were weaknesses in the way Mr Y was managed in Bedfordshire. Better communication between the various agencies could have led to a more comprehensive understanding of his behaviour patterns. Although this might have led the police investigating the various incidents to take a more robust approach to his questioning, without different evidence he would have been unlikely to have been charged and convicted. Closer inter-agency work would however have made it clear to him that the relevant agencies were working together. This might have exposed the inconsistencies in what he was telling his probation officer and what the police and children's services knew and could have led to tighter and firmer management by the probation service while he was under supervision.

8.3.2 BB's mother met both BB's father and Mr Y through internet dating sites. She has said that she was not aware of his history of domestic violence or of the allegations about injuries to children in Bedfordshire. It is recognised that such encounters can be risky and that those using such websites may not be honest about their identities

and backgrounds. The safety messages on such websites are about users' personal safety and not about the potential risks once they have begun to establish a relationship. At that stage, it is possible for a woman to use the provisions of "Claire's Law" to make an application to check whether a man with whom she is entering into a relationship has a history of domestic violence. Doing so does, however, require the woman to first of all consider that there could be such a risk.

8.3.3 While it cannot be said that Mr Y was responsible for BB's injuries, it is clear that his record, both of convictions and of police call-outs, was such that had the relevant agencies known he was spending time with BB, they would have wished to carry out a risk assessment. For this to have happened they would have had to have had some concerns about Mr Y as there is no expectation that health agencies should carry out such checks routinely. Had they had concerns they would have been likely to check with the Surrey Police and Probation Services. It would only have been if they had known about a Bedfordshire address that they might have checked with Bedfordshire Police and Probation Services and the different Children's Services in Bedfordshire. By the time Mr Y became involved in BB's care, he was no longer under the supervision of the probation service; had he been, then he might have told his probation officer about his new relationship and contact with the Surrey agencies could have been made.

8.4 The management of BB after admission to hospital in late May 2014

8.4.1 Some improvements in the transmission and, particularly, the recording of information have been suggested in order to give more certainty to Safeguarding processes.

9. CONCLUSIONS AND LESSONS IDENTIFIED BY AGENCIES

9.1 Conclusions

9.1.1 It is clear from the agency reviews and the interviews conducted with staff involved, that none of the agencies in contact with BB and mother were aware of any concerns about BB's wellbeing nor were they aware that BB's mother was in a relationship with a man with a history of domestic violence and allegations of ill-treatment of children.

9.1.2 There were therefore no actions that those agencies could have taken to protect BB.

9.1.3 Although they were not aware of his relationship with BB's mother, the agencies dealing with Mr Y in Bedfordshire should have liaised more effectively.

9.1.4 It is understood that Mr Y and BB's mother met through a dating website. This case illustrates the risks in making relationships with relatively unknown people, about whom little background information is available.

9.2 Actions by Agencies

9.2.1 The provider of local hospital and midwifery services has recommended:

- Improving the recording of actions taken and referrals made where vulnerability or risk is identified in the ante-natal period;
- Considering including in safeguarding supervision/midwifery supervision all cases where there is a maternal history of mental illness;
- Considering the creation of separate health records for the unborn to include all significant maternal vulnerability and risk issues.

9.2.2 The provider of the Paediatric Intensive Care Unit has identified:

- The need to ensure that communication between referring hospital staff and the PICU or specialist teams is recorded in advance of the child's arrival or retrospectively as soon as the child arrives.

9.2.3 The Bedfordshire Police have advised that:

- New processes will mean that all domestic related incidents will automatically be referred to the Domestic Abuse Investigation Unit, which will review the risk assessments, the history of the individuals concerned and the action taken during the initial response stage and will make referrals to partner agencies and contact the victim.

9.2.4 The National Probation Service, Bedfordshire Local Delivery Unit has, following its review of work carried out by the old Bedfordshire Probation Trust, recommended that:

- Procedures should be reviewed to ensure relevant information is retained from closed cases;
- Action should be taken to improve the practice of the responsible probation officer in relation to domestic abuse and other practice issues.

10. RECOMMENDATIONS

The following recommendations are made:

1. The actions planned by agencies, as listed in paragraph 9.2 are welcomed and it is recommended that they are endorsed by the Surrey Safeguarding Children's Board.
2. The Review has noted the concerns expressed in the reviews of the work of Bedfordshire Police and Bedfordshire Probation Trust about the deficiencies in their liaison. It recommends that the report of this Serious Case Review be provided to them and the three Safeguarding Children Boards and that Bedfordshire Police, the National Probation Service – Bedfordshire and BeNCH Community Rehabilitation Company be invited to review these processes together. This review could helpfully include the three Bedfordshire Children's Services and might be led or coordinated by the three local Safeguarding Children Boards.
3. Having identified concerns about liaison in Bedfordshire, it is also recommended that the Surrey Police, the National Probation Service – Surrey, the Kent, Surrey and Sussex Community Rehabilitation Company and the Surrey County Council Children's Services review their processes for liaison about incidents and call-outs in relation to domestic violence. Consideration should also be given to how any requests from health and social care agencies for information about offenders are handled so that contact with the police and probation services in other areas is also checked as far as is possible.
4. BB's mother met her partner, Mr Y, through an internet dating site and has said that she was unaware of his behaviour in his previous relationships. It is recommended that consideration be given to how mothers can be alerted to the need for caution when engaging in new relationships with previously unknown men, potentially with an emphasis on relationships made through internet dating sites and social media. This is a concern that crosses boundaries and it is recommended that it be referred for national consideration and action.

Arthur Wing — March 2017
Independent Reviewer/Author

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Appendix 1

Composition of the Serious Case Review Group

Alex Walters	SSCB and SCR Panel Independent Chair
Designated Nurse for Child Protection	Surrey Clinical Commissioning Group
Director of Quality and Executive Nurse	Surrey Clinical Commissioning Group
Deputy Director	Children, Schools & Families, Surrey County Council
Head of Safeguarding	Surrey County Council
Assistant Director	Schools & Learning, Surrey County Council
Assistant Director	National Probation Service – Surrey
Director	Kent, Surrey and Sussex Community Rehabilitation Company
Detective Superintendent	Surrey Police
Head of Youth Support Services	Surrey County Council

In attendance

Case Review Administrator	Surrey Safeguarding Children Board
Partnership Support Manager	Surrey Safeguarding Children Board
Arthur Wing	Independent Reviewer

Appendix 2

Terms of Reference of the SCR

1. Did agencies communicate effectively and work together to safeguard and promote the child's welfare?
2. Was the level and extent of agency engagement and intervention with the family appropriate? In view of the difficulties that Health Services had in contacting the mother. Were assessments undertaken in a timely manner, was the quality adequate and did they include fathers, extended family and all historical information?
3. Was any information known by any agency about parental mental health issues, domestic abuse, substance misuse or parental antisocial behaviours or concerns re neglect? If so was appropriate consideration given to how these impacted on parenting capacity and were appropriate referrals made?
4. What information was known by agencies about the wider family in particular BB's father, mother's partner, maternal grandparents and maternal great grandparents? Who were all involved in BB's care?
5. Did Bedfordshire Probation services know that BB's mother's partner was living in Surrey and in a relationship which enabled contact with Children?
6. Was there sufficient consideration of the vulnerability of this family in relation to their housing situation and the impact on their parenting capacity and what support was provided?
7. Were the children's views and wishes sought and taken account of in assessments and planning? Did this include the presentation of these young non-verbal children being fully considered?
8. Were any safeguarding issues in respect of BB identified and acted on appropriately and in a timely way by all agencies?
9. Were missed appointments and failure to engage considered as indicators of neglect?
10. Was race, religion, language, culture, ethnicity or disability a factor in this case and was it considered fully and acted on if required? How was the uniqueness of this particular family recognised?
11. Were there any organisational or resource factors which may have impacted on practice in this case?
12. Were appropriate management/clinical oversight (supervision) arrangements in place for professionals making judgments in this case?

15 September 2014