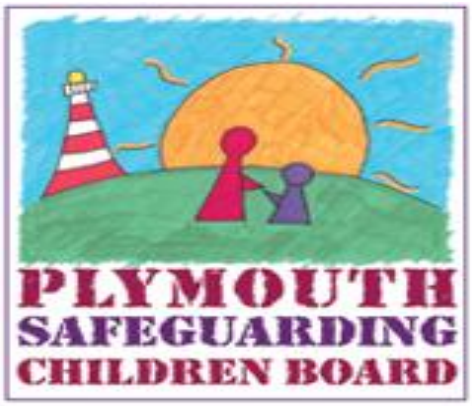

SERIOUS CASE REVIEW

BABY G

Independent Reviewer
Karen Tudor

May 2019

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INTRODUCTION

Events Leading to this Serious Case Review

1. In May 2017 a six month old baby was taken to hospital where he was found to have suffered a significant head injury; the baby died three days later. Investigations found that, at the time of the injury, the baby was in the care of his father; the father was charged in connection with his death and subsequently pleaded guilty to manslaughter; he is currently serving a prison sentence. The baby is to be known in this review as Baby G.

Conducting a Serious Case Review

2. When abuse or neglect of a child is known or suspected and either the child has died or been seriously harmed and there is cause for concern as to the way in which services have worked together to safeguard the child, the Local Safeguarding Children Board (LSCB) has to consider whether a Serious Case Review should be carried out.

3. The Plymouth Safeguarding Children Board (PSCB) under Regulation 5 of the Local Safeguarding Children Boards Regulations, 2006, decided the criteria were met for a SCR. The recommendation was confirmed by the Chair of the PSCB and notification of the decision was made to the Department for Education.

4. The purpose of the Review as defined by Working Together (2015) is:
    - To establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
    - Identify clearly what those lessons are, how they will be acted upon and what is expected to change as a result

5. As a consequence, improve interagency working and better safeguard and promote the welfare of children1

The Process of the Review

6. An Independent Reviewer was commissioned and the process overseen by a Serious Case Review Group, this is a sub-group of the Local Safeguarding Board comprised of

[1] Working Together to Safeguard Children, 2015

senior managers and clinicians none of whom had had direct involvement with the case; this group set out the terms of reference and agreed the review would cover the period leading up to Baby Gs birth (the pregnancy) until the date the injuries were diagnosed, a period of just over a year.

(See Appendix for a list of SCR Group members)

Parallel Investigations/Enquiries

7. Because of the criminal proceedings, the SCR was conducted in accordance with the guidance "Liaison and information exchange when criminal proceedings coincide with Chapter Four, Serious Case Reviews or Welsh Child Practice Reviews."[2] This guidance suggests a framework for the sharing and exchange of relevant information generated by Serious Case Reviews and a criminal prosecution to prevent one adversely affecting the other. Working within this framework enabled the Safeguarding Board to ensure there was no unnecessary delay in concluding the SCR because of the criminal proceedings and identify any learning as soon as possible after the events.

Method

8. The Review must be conducted in line with government guidance, Working Together to Safeguard Children, 2015. In view of the move towards using systemic models and practitioner involvement to promote learning, the Board decided to use a review model known as a Partnership Learning Review. Involving practitioners, the baby's family and working with the Serious Case Review Group, the Review addresses the question of who did what and why and identifies themes for learning. The methodology also recognises that people work in complex organisations where a range of factors can impact on the nature of the work and where relevant, these are reflected in the analysis.

9. A chronology of events was requested from the agencies who had worked with the family, and, because it was not advisable in light of the criminal investigation to hold meetings of practitioners, those who had worked with the family were invited to meet the Independent Reviewer individually or in single agency groups. The findings are summarised in the Conclusion and Learning and Considerations for the PSCB.

10. As part of the analysis and based on the referral information, the Independent Reviewer was asked by the SCR Group to consider the following issues:
    - Early identification and dynamic risk assessment;
    - Child's multiple presentations at the hospital emergency department;
    - Involvement and effective engagement with fathers.

[2] **Liaison and information exchange** when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews, A Guide for the Police, Crown Prosecution Service and Local Safeguarding Children Boards, May 2014

Anonymity/ Publication

11. For the purposes of publication of the report, details of the family history and current circumstances are kept to a minimum. The names of individuals have been anonymised.

12. Key people are:

    - Baby G - the subject child, born November 2016, died May 2017
    - Ms BM - Baby G's mother
    - Mr BF - Baby G's father

Family Involvement in the Review

13. Both of Baby G's parents were invited to participate in the Review and both met with the Independent Reviewer; their contribution to the review was highly valued by the Reviewer and SCR sub- group, their comments are included in the report.

Ms BM said of Baby G...

> "*from the moment (Baby G) made his entrance into the world, wide eyed and in utter awe of everything around him, it was clear he was going to be a character. He was a beautiful baby and I fell instantly in love with him as did the rest of my family and friends. The few short months we had with him were so precious and it hurts so much to know we should have had more. (Baby G) was a son, nephew and grandson - he is missed so much it hurts...*"

BACKGROUND TO THE CASE

14. Ms BM was aged 18 when she became pregnant, this was her first baby; records indicate that she had known the baby's father for a few weeks.

15. Midwifery recognised that Ms BM was vulnerable, she told the midwife she had had a troubled childhood and been subject to a Child Protection Plan, she was estranged from her mother.

16. Little was known about Mr BF; Baby G was his second child, his older child lived with their mother and he had no contact, although none of the practitioners knew the reason for this.

17. During the pregnancy Baby G's parents were living separately in inadequate housing, Ms BM was referred to a housing organisation which provided supported accommodation for young parents; she moved in a few months before Baby G was born; Mr BF was living in a hostel and later moved to a privately rented room in a shared house.

18. Support from the couple's families was thought to be very limited for both parents.

19. Ms BM engaged well with midwifery and attended most of her appointments; she had some significant health issues during the pregnancy and responded well to treatment. Mr BF was seen as a supportive partner and attended ante-natal appointments with Ms BM, none of the practitioners who met them had any concerns about their relationship or preparation for the new baby.

20. Baby G was born three weeks early, although small (5lbs 13oz), he was a healthy baby and his weight was within normal limits. He left hospital with his parents and lived with his mother.

21. The housing project provides young parents with support, staff are on site 24 hours a day; Ms BM was allocated a key worker and she engaged well with staff often seeking support and advice.

22. Ms BM was described by the housing project staff as an anxious parent and Baby G as a sickly baby; it later transpired that Baby G had intolerance to a protein in milk and once this was diagnosed (aged 3 months) he reportedly became much more settled.

23. An indication of Ms BM's anxiety was the frequency of attendance at the family GP practice and three attendances at the local hospital emergency department which were partly prompted by the need for reassurance; the baby was also monitored by a paediatrician because of a suspected change in his head circumference.

24. Three weeks before Baby G died Ms BM became unwell in the early hours of the morning; although she recovered, the incident reportedly caused her significant anxiety. Baby G had already spent regular nights with his father and, following Ms BM's experience, the arrangement became more frequent. It was ten days later that Baby G sustained his fatal head injury.

Agencies Involved with the Family

- Midwifery
- Health Visiting
- GPs
- Local Hospital, Accident and Emergency and Paediatric Department
- Housing Provider – supported accommodation for young parents
- Children's Social Care – 2 contacts noted, neither of which led a referral or any ongoing work
- Police – 1 notification about a domestic incident regarding Baby G's paternal aunt
- Ambulance Service – provided advice about managing vomiting on one occasion and transport to hospital on one occasion

25. During the period of this Review, although the family were regarded as vulnerable, there were never any safeguarding concerns and therefore the case did not meet the threshold for assessment by Children's Social Care; Early Help[3] was considered and although this would have provided a framework for assessment, intervention and review of progress, Ms BM would not agree to what she reportedly saw as a formal intervention.

26. Baby G's tragic death was a great shock to the practitioners who knew the family.

[3] **Early Help** – this is a shared assessment and planning framework for use across all children's services and all local areas in the UK. It promotes early identification of a child and family's additional needs and a coordinated service provision to meet them

SUMMARY OF EVENTS

BABY G'S AGE	EVENT	COMMENT
	Midwifery contact Children's Social Care to discuss Ms BMs vulnerability.	
7 months pregnant	Ms BM moves into supported housing Mr BF is living in a hostel.	
	Baby G born	
Aged 1 month	Health Visiting concerned about the way the couple speak to each other, plans to ring CSC for information.	This was not followed up.
	Paediatric admission, vomiting and blood streaks, crying a lot.	
2 months	Baby G seen in ED, rash on chest and face.	
3 months	Paediatric Review, head circumference has changed.	Ultrasound scan arranged, nothing abnormal detected.
	Baby G Tested for intolerance to cow's milk.	Later found to have a milk protein intolerance.
	Ms BM tells her GP she is depressed.	Prescribed anti-depression medication.
	Ambulance called, Baby G seen in ED "inconsolable crying."	Hospital routinely notify their safeguarding team as third attendance, no safeguarding concerns identified.
4 months	Out of hours doctor called, Baby G diarrhoea and vomiting, to see GP next day.	
	Ms BM sees GP × 2 , shortness of breath and later depression, not eating.	
	Call to NHS 111, Baby G won't settle, persistent crying, advice given	
	Ms BM seen in ED, chest pains.	No treatment necessary.

5 months	Telephone contact with GP, Baby G has a rash.	
6 months	Baby G paediatric review, referred to dietician about milk intolerance.	
	Ms BM is unwell in early hours of the morning.	
	Baby G is cared for overnight more frequently by his father.	
	Police attended domestic dispute between a member of Baby G's family and a friend. Baby G was present but removed to a safe place.	
	Baby G is admitted to hospital with a head injury. Three days after the injury life support was withdrawn and Baby G died.	

AGENCY INVOLVEMENT WITH THE FAMILY

Midwifery

27. Ms BM booked in with midwifery in good time and attended most of the planned appointments; feedback from the practitioners indicate she engaged well, sharing information about her childhood history and how she was managing the pregnancy.

28. Ms BM had some medical problems during the pregnancy which required treatment and extra monitoring, she smoked and in the early stages, acknowledged she wasn't eating well.

29. Mr BF attended appointments with Ms BM. Midwifery assessment concentrates primarily on mothers, if fathers are present they are asked for details of their name, address and any medical issues relevant to the unborn baby. Questions about possible domestic abuse are not asked in the presence of fathers and exploration of other issues such as possible drug and alcohol use is done in general terms for example "are there any issues *in the home*?"

30. The midwives who were caring for Ms BM described how they rely on picking up cues about mothers, fathers and their relationship and if they sense that there might be safeguarding issues or additional support needs, then they will probe and question further before deciding what action to take. The midwife, having seen the parents together on several occasions, had no concerns about the couple and their relationship.

31. They did have some questions about Ms BM's extended family and some historic safeguarding concerns and the midwife wanted to be sure that there was no risk to the unborn baby. In order to explore this further, the midwife contacted Children's Social Care to discuss the case, the outcome of the discussion was that the threshold for intervention by Children's Social Care was not met and no further action was taken. The midwifery team were advised to contact Children's Social Care again if more information came to light.

32. Baby G was born in hospital November 2016, two weeks before his due date. Although he was a small baby, there were no concerns about his health and he was discharged home with his mother.

Health Visiting

33. There was a handover from Midwifery to the local Health Visiting team in line with expected practice and a pre-birth visit took place 7 weeks before Baby G was born.

34. The Health Visitor and Midwife had a conversation about Ms BM's vulnerability and that midwifery had been in contact with Children's Social Care to discuss her concerns about the historic safeguarding concerns. This conversation led to a misunderstanding, the Health Visitor believed that Midwifery had made a referral to Children's Social Care who were carrying out an assessment. Health Visiting were aware that they heard nothing from Children's Social Care but reported this was not unusual, they did not seek information or ask about the outcome of the assessment.

35. In this case, whilst this misunderstanding did not impact the ongoing work, it raises an important point about the need for clear and accurate information sharing and the responsibility for all agencies to seek information if they believe an assessment is being carried out.

36. The Health Visitor met Ms BM and carried out an assessment which included a discussion of Ms BM's family history, she also sought the views of the staff at the housing project about Ms BM's preparation for the baby's birth. Like midwifery, the Health Visitor noted that Ms BM had limited family support and had had a troubled childhood, she concluded Ms BM was vulnerable and offered her an enhanced Health Visiting service, known as the MESCH programme (Maternal Early Childhood Sustained Home Visiting)[4] or access to the Family Nurse Partnership. (FNP)[5] Ms BM was asked to think about whether she would like to participate in either of these programmes.

37. Ms BM declined the offer of both the MESCH programme and the FNP and it is interesting to note that, soon after this visit, Ms BM requested a change of Health Visitor expressing the view to staff at the housing project that she had found the conversation with the Health Visitor very intrusive. This was a surprise to the Health Visitor who felt the visit had gone well and she and Ms BM were forming a good working relationship.

38. Ms BM has no recollection of being offered an enhanced service and expressed the view that she would have welcomed any additional support.

39. On reflection, the practitioners in this case felt that Ms BM was often uncomfortable with conversations which she felt revealed information about her early life; with hindsight, even the practitioners who spent many hours with Ms BM knew relatively little about her.

40. The case was transferred to another Health Visitor who saw Ms BM and Baby G on average once a fortnight throughout the baby's life. The service was Universal Partnership Plus.[6]

41. It is notable that all the visits to Baby G and his mother were conducted in the shared lounge where other residents may well be present; the Health Visitor had asked to talk to Ms BM in her room but she had refused on the grounds it was untidy; this

4The Maternal Early Childhood Sustained Home-visiting (MECSH) programme is an evidenced based, structured programme of intervention for vulnerable mothers which encompasses primary health care and can include more specialist services as required.

5 Family Nurse Practitioners (FNP) are advanced practice registered nurses who work autonomously or in collaboration with other healthcare professionals to deliver family-focused care from pregnancy until a child turns two. They can work on a variety of issues for example, parent-child attachment, breastfeeding, child may help improve self-confidence as well as support on issues such as mental health, anxiety, housing and stopping smoking.

[6] Universal Partnership Plus provides ongoing support from the health visiting team and a range of local services to deal with more complex issues over a period of time.

inhibited private and confidential discussion and also meant the Health Visitor was not able to assess the baby's sleeping environment and any impact of this on his health and well being.

42. During the first visit the new Health Visitor expressed concern about the way Mr BF spoke to Ms BM, when she felt he had used inappropriate language; the housing staff, who were present at the time and were less concerned, recorded that the Health Visitor intended to follow this up by making an enquiry with Children's Social Care to find out if Mr BF was known to them, however there is no evidence this intention was acted on.

43. Health Visiting communicated well with staff at the housing project where Baby G was living which, along with their visits to the baby, reassured them that there were no concerns about Ms BM's parenting capacity.

44. Following several visits to the local hospital, (see below for detail) the hospital informed Health Visiting when Baby G had been brought in and why and sent a discharge summary. Each of the visits concerned, what were considered by clinicians, to be relatively minor health issues, for example a rash, diarrhoea and blood in vomit; none raised any safeguarding concerns or questions about parenting capacity.

45. A domestic abuse notification was sent to Health Visiting informing them about a domestic incident which took place a week before Baby G's death. This involved a family member and a friend; Baby G was present but was promptly removed from the scene and was not hurt.

46. The domestic abuse notification to Health Visiting would have been received by the team's generic email and forwarded to the lead Health Visitor who happened to be on leave at the time; although it would have been expected that another practitioner would have reviewed the information there was no clear process in place at the time and no evidence that the notification was seen or considered.

47. There was also a notable gap in communication between Health Visiting and the General Practice; at no time during Baby G's life did Health Visiting have any contact with Baby G's, his mother's or his father's GP. This meant that neither the GPs or Health Visiting had a full picture of the family.

48. Mr BF was at the housing project frequently and played an active role in Baby G's care, regularly taking him for overnight stays. It is notable that Health Visiting knew very little about Mr BF. They knew he had an older daughter with whom he had no

contact but did not know why this was and had not asked anything about Mr BF's history or made any attempt to assess his parenting capacity. The domestic abuse routine enquiry questionnaire had not been completed despite the number of visits to Ms BM.

49. Health Visiting were unaware that both Mr BF and Ms BM had been diagnosed with depression. (See GP involvement)

50. The Health Visiting Service have carried out a review of their own practice and made a number of recommendations for improvement; the PCSB should satisfy itself that learning is embedded in practice and the proposed actions are implemented. (See Recommendations to the PSCB)

GP Involvement with the Family

51. Ms BM and Baby G were registered at a local GP practice where they were considered "frequent attendees" although the frequency was not considered unusual for a young parent with a "sickly baby;" staff at the practice reported they would always encourage parents to come in if they were worried about young babies.

52. The attendances (which averaged at about 2 a month during baby G's life) were for minor illnesses, for example a rash, diarrhoea; he was diagnosed with a milk protein intolerance when he was about a month old.

53. Mr BF attended with Ms BM and Baby G on some occasions, on others a member of staff from the housing project accompanied Ms BM and the baby.

54. Communication between the surgery and the local hospital was good, discharge summaries were sent in good time and the paediatrician rang the surgery on one occasion to clarify progress over a planned scan when the baby's head circumference was being checked.

55. During the period of the review Mr BF was registered at a different practice; his health history was unremarkable except he had been diagnosed with depression in the early stages of Ms BM's pregnancy.

56. Ms BM reported that she found attending the GP stressful, she felt she was being "fobbed off," "not listened to" and "dismissed as a young mum." Staff at the housing

project confirmed that they frequently accompanied Ms BM (and other residents) on visits to the GP to help young parents express their concerns clearly.

Parents and Diagnosis of Depression

57. In 2017 a Serious Case Review was carried out in Plymouth after an eleven week old baby was seriously harmed from a traumatic head injury. Yet to be published, one of the learning themes from the Review was about the diagnosis and treatment of post-natal depression; in that case both parents had been diagnosed with depression shortly before the injuries occurred.

58. Similarly in this case, both Baby G's parents had been diagnosed with depression, his mother when the baby was about 4 months old and his father during the pregnancy.

59. The numbers of people diagnosed with depression in the UK has risen dramatically in the past few years, NHS statistics show that as many as 1 person in 6 is being treated with anti-depressant medication.[7]

60. In view of these statistics it is not surprising that, in this case, neither of the GPs who made the diagnosis and prescribed the medication regarded it as medically or socially significant.

61. The impact of depression on parenting is well documented;[8] what is significant, in this case is that there is no information recorded about any underlying factors which might contribute to depression, for example stress related to the prospect of becoming a parent or managing a crying baby; the Health Visitor was unaware of the diagnosis and therefore did not explore any factors which might have been associated with depression with either parent. (See Learning)

62. This gap in knowledge was further compounded by the general lack of curiosity about Mr BF and the Health Visiting services' inability to see Ms BM away from others living in the housing project.

63. It is notable that there was no communication between the GPs and Health Visiting about this family during Baby G's life; this is not unusual if there are no particular safeguarding (or other) concerns about a family but it does mean that, for vulnerable families, no one health professional has the full picture.

[7] Numbers of people with depression- mixed anxiety and depression is the most common mental disorder in the UK with 7.8% of the population meeting the criteria for diagnosis. 4-10% of people will experience depression in their lifetime. Mental Health Foundation Statistics, 2018

[8] See for example NSPCC, Parents with Mental Health problems: Learning from Case Reviews.

Local Hospital – Paediatric Department and Emergency Department

64. Baby G was seen in the Emergency Department of the local hospital on three occasions aged 3 weeks, 8 weeks and 11 weeks. The first visit was because of persistent crying and vomiting and he had some blood streaks in his vomit; the second because he had a rash on his chest and face and the third because of "inconsolable crying."

65. At each visit the baby was assessed, given any necessary treatment and his parents were given advice, none of the medical conditions was considered to be serious; the blood in his vomit was considered to be consistent with a tear in the oesophagus or stomach caused by vomiting, thought to be Mallory-Weiss Syndrome.

66. Mallory-Weiss Syndrome is rare in infants and children without co-existing medical problems, however bleeding from the nose or mouth is a recognised presentation of the much more common, possible child abuse. It is important to operate a level of professional curiosity when presented with signs and symptoms which are unusual and clinicians should be aware of the relevant hospital policies and guidelines. Oro-nasal bleeding in a baby was also a feature in the previous, recent SCR (yet to be published) and raising awareness if its significance remains a challenge for all practitioners. (See Considerations for the PCSB.)

67. The hospital Safeguarding Policy states that if a baby/child is seen on three separate occasions, a notification must be made to the hospital Safeguarding Team; this provides a holistic over-view of the case and an opportunity for a specialist safeguarding practitioner to consider if there is any indications of a need for a referral to Children's Social Care or any further follow up;

68. The Safeguarding Team looked at Baby G's presentations and decided there were no indications of risk or harm or concerns about parenting capacity.

69. Baby G was also seen by a Paediatrician following a referral to investigate a possible increase in his head circumference[9]. The Paediatrician ordered a cranial ultra-sound scan and discussed the results with a specialist paediatric radiologist; the scan showed no abnormalities; the Paediatrician also discussed the family with the Health Visitor and was reassured that the Health Visitor had no concerns about the baby or his care.

[9] Increase in his head circumference can be indicative of a medical disorder which might require further investigation or treatment, for example hydrocephalus or craniosynostosis. A CT scan gives a better resolution and is more likely to identify an inter-cranial injury including bleeding.

70. Although a CT scan or MRI scan may be considered if a baby has an increasing head circumference[10], the Paediatrician was conscious that the only earlier measurement of the baby's head had been taken at birth by a midwife; where the tape is placed can make a difference to the measurement and therefore a comparison is unreliable. The paediatrician concluded the baby was clinically well and asked the Health Visitor to monitor the head circumference which appeared to level out.

Young Parents' Housing Project

71. Baby G lived with his mother in supported accommodation; Ms BM had moved in three months before Baby G was born. The project provides housing for 15 young parents, the accommodation provided is a bedsitting room, kitchen and bathroom facilities are shared and there is a communal lounge. The project is staffed for 24 hours every day.

72. Ms BM was preparing to move into the community around the time that Baby G died.

73. Staff at the project described Ms BM as an "anxious new mum who required a lot of support and reassurance from staff regarding her parenting in the early days." Baby G was described as a "sickly baby" who cried a lot and could be "fretful."

74. Ms BM was also described by staff as sociable and said to enjoyed the company of the other mothers and their babies, she took an active part in house meetings and engaged well with members of staff, seeking support on a daily basis. A member of staff would sometimes accompany Ms BM on visits to the doctor, encouraging her to be assertive when necessary.

75. Mr BF was a regular visitor at the house, he was described as initially quite quiet, but as his confidence grew he became more sociable. Mr BF was described as "not helping much" with Baby G's care although it is notable that he was often the parent who settled Baby G when he was fractious when he would lie with the baby on his chest; such was his reputation that other parents would ask Mr BF to care for their babies for short periods when they wanted to go outside for a cigarette.

76. Although staff at the housing project saw Mr BF with Baby G on many occasions and he spent time at the project talking with them and other residents, the practitioners

[10] See The Royal College of Radiologists, Standards for radiological investigations of suspected non-accidental injury, September 2017

felt they knew little about him. Mr BF would take Baby G home with him for occasional nights and, although Ms BM had commented that he sometimes handled the baby roughly, they never had any concerns about his care of the baby which would have warranted intervention by staff.

77. To summarise, staff at the housing project spent a considerable amount of time with Baby G and his parents and at no time did they feel that Baby G was at risk of harm.

78. In the light of Baby G's death Health Visiting are providing drop in sessions for residents at the project about safe handling to which fathers are invited.

79. More effective engagement with fathers from the early stages of pregnancy is addressed in the conclusion of this report.

Police

80. The only contact the Police had with this case was to issue a notification of a domestic incident between Baby G's paternal aunt and a friend. Baby G was present but promptly removed to safety and there were no concerns that Baby G had suffered any harm.

81. The incident occurred a week before Baby G's death; in line with policy, notifications were sent to Children's Social Care, where the facts were logged but the incident was not serious enough to warrant any action; a notification was also sent to Health Visiting.

Children's Social Care

82. There were two contacts with Children's Social Care during the period of this Review, the first was from midwifery when Ms BM was pregnant; the midwife rang because she was concerned to know if the baby (as yet unborn) was likely to be at risk from a member of Ms BM's extended family. Following a discussion, both agencies agreed there was insufficient information for any action to be taken; Ms BM had moved to the area relatively recently and Children's Social Care had no background history on file. (It took some time to clarify where Ms BM had lived before moving to the area and, although this did provide further indications of her adverse childhood experiences and subsequent vulnerability, in considering her current circumstances the case did not meet the threshold for intervention by Children's Social Care.)

83. There was some confusion about the midwife's call when Ms BM was discharged home with Baby G, Health Visiting thought Children's Social Care were carrying out an assessment of the family; however when they heard nothing, the matter was not pursued.

84. The second contact, when Baby G was eleven weeks old, was from the hospital Emergency Department; Baby G had been brought to hospital because his parents were worried about his "inconsolable crying." Hospital staff contacted Children' s Social Care to ask if the family were known to them, as they were not there was no further action and Children's Social Care noted the call as "for information only."

Ambulance Service

85. The ambulance service had very limited contact with the family, they provided advice about managing vomiting on one occasion and transport to hospital on one occasion. Staff who observed Baby G with his parents had no concerns about their parenting capacity or Baby G's safety.

CONCLUSION AND LEARNING

86. The learning from this case arises from the question of whether there were opportunities to prevent the abusive head trauma which caused Baby G's death.

87. Whilst carrying out a review of this nature there will inevitably be areas of practice which could have been better, these have been identified by the respective agencies and prompted their own learning.

88. The conclusion of this review is that the work with Baby G and his family was generally thoughtful, purposeful and proportionate.

89. A practitioner described Baby G's death as "a bolt out of the blue" a view shared, without exception, by all the professionals who knew the family.

Abusive Head Trauma (AHT)

90. Defined as "an inflicted injury to the head and its contents" and "associated with a spectrum of serious and often permanent neurological consequences" abusive head trauma is seen as a leading cause of death in children under 2 years old.[11]

91. Alison Kemp in her paper "Abusive Head Trauma: Recognition and Essential Investigation" states that:
"Abusive head trauma (AHT) affects one in 4000–5000 infants every year and is one of the most serious forms of physical child abuse that has a high associated mortality and morbidity." [12]

92. The US government estimates that about 30 children, younger than one year of age, per 100,000 are injured from AHT, resulting in at least 1200 seriously injured infants and at least 80 deaths each year.[13]

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13 Abusive head trauma: Evolution of a diagnosis
Issue: BCMJ, Vol. 57, No. 8, October 2015, page(s) 331-335
Margaret Colbourne, MD, FRCPC

[12] Abusive head trauma: recognition and the essential investigation Alison M Kemp, Abusive head trauma: recognition and the essential investigation Alison M Kemp. BMJ, September 2012

[13] Parks SE, Sugerman D, Xu L, Coronado V. Characteristics of non-fatal abusive head trauma among children in the USA, 2003-2008

93. Altman et al[14] quotes
"The person most likely to shake an infant is the father or a male surrogate. Shaking typically is triggered by the caregiver's inability to stop the infant from crying."

94. The research proposes that AHT is largely preventable and suggests that the most common incident leading to abusive head injury is infant crying.
Reijneveld et al describe that:
"*Exhausted parents and other caregivers may become frustrated and angry and "lose it" when infants in their care cry inconsolably*" [15]

95. Dr Suzanne Smith's work on abusive head trauma refers to the normal peak of crying known as the "crying curve" and highlights the relationship between crying and abusive head trauma caused by shaking which peaks at 9-12 weeks.16

96. In this case there were several occasions when Baby G was seen by health practitioners because of relatively minor medical problems, vomiting and a rash and he was taken to hospital at 3, 8 and 11 weeks when the record refers, most notably, to his "inconsolable crying."

97. There was also a call to NHS 111 from his parents seeking advice about his crying.

98. The PCSB will also be mindful of the previous Serious Case Review, regarding a baby who, aged 11 weeks, suffered a catastrophic head trauma.[17]

What can we learn from Mr BF's experience?

99. Ms BM and Mr BF were both delighted at the prospect of becoming parents; Mr BF described himself as inexperienced with babies and when Baby G was born he was initially anxious about holding and feeding him, although he felt he gained confidence with time.

100. Mr BM learnt to make up bottles, change a nappy and how to care for Baby G from observing Ms BM and other parents, he reported that he had little involvement with the practitioners who met with Ms BM both during the pregnancy and after Baby G

[14] Parent Education by Maternity Nurses and Prevention of Abusive Head Trauma
Robin L. Altman, Jennifer Canter, Patricia A. Patrick, Nancy Daley, Neelofar K. Butt, Donald A. Brand
[17] Reijneveld SA, van der Wal MF, Brugman E, et al. Infant crying and abuse. The Lancet 2004;364:1340-2.
[16] Dr Suzanne Smith, Mechanisms, Triggers and the Case for Prevention, January 2017
[17] Plymouth Safeguarding Children Board, Serious Case Review, Baby F, August 2017, publication pending

was born but he did not find this surprising as he felt they were there for Ms BM and his role was just to support her.

101. Mr BF described the stresses both he and Ms BM struggled with from time to time, the ups and downs and arguing in their relationship, his own anxiety and depression and Baby G's crying.

102. It was Baby G's persistent crying which led to Mr BF shaking him, he described how Baby G cried and cried and how he wanted him to stop. Mr BF said his efforts to calm the baby were unsuccessful, he felt he couldn't leave the baby alone at such a young age and also, living in one room in a shared house, he had no-where to go. Mr BF was still angry from an argument he had with Ms BM the previous day and was also tired from his own lack of sleep. Mr BF admitted he shook Baby G until Baby G stopped crying, he says he didn't know shaking babies was so dangerous and he underestimated his own strength.

103. Mr BF admitted causing Baby G's death and pleaded guilty to manslaughter.

RECOMMENDATIONS FOR THE PLYMOUTH SAFEGUARDING CHILDREN BOARD (PSCB)

1. The PSCB reassures itself that the individual agency learning from this case is embedded in practice; this is particularly pertinent to the Health Visiting Service who identified practice shortfalls of a similar nature to those found in a previous Serious Case Review. (not yet published[18])

2. The PSCB should assure itself that all partners recognise that seemingly minor presentations can represent sentinel injuries which may presage serious abusive trauma.

3. That the PSCB considers the concept of prevention of abusive head trauma and develops a strategy to address this.

   To include:

   - The promotion of awareness among parents and professionals of the "crying curve" (also known as "purple crying") and the impact on parents of coping with inconsolable crying;
   - Understanding more about patterns of abusive head trauma and the associated risk factors;
   - Reflection on the diagnosis and treatment of depression in new and prospective parents and how this can impact on parenting capacity;
   - Developing a programme of intervention which takes into consideration when and how to engage fathers and prospective fathers;
   - The use of materials to engage, reassure and educate parents about infant crying and strategies for coping and impulse control.[19]

[18] Plymouth Safeguarding Children Board, Serious Case Review, Baby F, August 2017, publication pending,

[19] For examples see West Hampshire CCG - ICON project, Inspire Cornwall- the concept of the DadPad and associated App, the NSPCC's "Coping with Crying" materials

APPENDICES

Members of the SCR Group

- Detective Chief Inspector, Public Protection Unit, Devon and Cornwall Police (Chair)
- Designated Doctor Safeguarding Children, NEW Devon CCG
- Head of Safeguarding (Children and Adults) NEW Devon CCG
- Head of Safeguarding, Children Young People and Families, Plymouth City Council
- Plymouth Safeguarding Children Board Manager