

**Northamptonshire Safeguarding Children
Board**

The Overview Report

into a

**Serious Case Review of the Circumstances
Concerning**

Leah Barnes

Independent Author

Dr John FOX MSc, PhD

January 2014

CONTENTS	PAGE
1. Introduction	2
2. Process of the Review	4
3. The Facts - Summary of agency involvement	14
4. A Day in the life of Leah and her family	22
5. Analysis of Practice and the Lessons Learnt	23
6. Relevant findings from previous SCR's	54
7. Conclusions and Summary of what has been learnt	56
8. Recommendations for LSCB	57
List of References	60
Appendices Appendix A – Terms of Reference Appendix B - Letter to family members	61

1. Introduction

1.1 Who was Leah Barnes?

1.1.1 Leah was the younger of two children of Della Barnes and Mark Dennis. She was 19 months old when she died as a result of severe trauma which occurred during a violent assault when she was 7 weeks old. She was in the care of her parents at the time of the assault and thereafter spent the rest of her life as a severely disabled person receiving constant care.

1.1.2 Until her death little was known about Leah but she was not born with any known health issues. Leah and her mother received routine postnatal care including 6 home visits by a community midwife. Nothing was recorded to indicate that the interaction between Leah and her mother was not appropriate. The GP had extremely little contact with the family.

1.1.3 The relationship between Leah's parents has been described as 'on/off'. After the birth of Leah's elder brother they parted, but Mark Dennis applied through the courts for contact arrangements. By the time Leah was born, the couple were together and Mark was present at the birth. Because he was stationed at a military base however, he was not a constant presence within the household.

1.1.4 Very little is known by professionals about the interaction between Leah and her father Mark Dennis. Leah's father was a serving soldier who had suffered very severe injuries during combat. There is evidence that he was a troubled and violent man, and there were reported episodes including one or more attacks on Leah's maternal grandmother.

1.1.5 It should be noted that in this Overview Report all family names have been changed to provide a level of anonymity.

1.2 Summary of Circumstances Leading to the Review

1.2.1 At around 1700 hours on the 8th May 2011 Nenedoc Northampton, who were providing out of hours coverage for the family GP, were called by one of her parents who reported that Leah was "un-rousable" and "very cold to touch". The advice given was to call 999.

1.2.2 However, 15 minutes later Leah's parents presented Leah at Northampton General Hospital. On admission she was found to be unresponsive and in respiratory arrest. The paediatric resuscitation team started work on Leah immediately and she was revived with oxygen and then intubated and ventilated.

1.2.3 Once a full examination had been conducted it was discovered that Leah had multiple injuries and the medical opinion was that the cause of the injuries was non-accidental. Leah's injuries included a fracture to her skull, bleed on her brain, bleed on her spine, multiple retinal haemorrhages, multiple rib fractures, fracture to her right elbow, and thoracic vertebral fractures. Radiological and post mortem examination later revealed that the injuries were caused over a period of time and not during one catastrophic attack. At a subsequent Looked After Child Review meeting the summary completed by a social worker included the information, *'Professional, independent paediatric medical reports have concluded that Leah's injuries were inflicted upon her deliberately and that they were sustained during four separate attacks.'*

1.2.4 Leah was transferred to a hospital in Oxford where she remained for several weeks until being transferred to the care of her maternal Grandmother and, towards the end of her life, a hospice. From the time of her injuries being sustained until her death on 7th November 2012, Leah remained a very sick child and in particular, suffered from severe brain damage, epilepsy, pain, feeding difficulties, and constipation.

1.2.5 During the period when Leah was being treated in the Accident and Emergency Department, Northamptonshire County Council Out of Hours Service was contacted and they in turn contacted the police. A Detective Chief Inspector commenced a criminal investigation and Leah's parents were both arrested. Her father was later charged with her murder.

1.2.6 A Serious Case Review is not concerned with establishing culpability but at a Fact Finding hearing in connection with care proceedings in March 2012, the Family Court Judge indicated that he would find that Mark Dennis caused the injuries to Leah and failed to seek timely medical treatment for her, and that Della Barnes failed to protect Leah. Furthermore, on 12th April 2013, the Crown Prosecution Service (CPS) authorised that Mark Dennis should be charged with the murder of Leah Barnes. In order to reach that conclusion, the CPS had to decide that there was a realistic prospect of conviction which was 'beyond reasonable

doubt'. On 8th November 2013, at Northampton Crown Court, Mark Dennis pleaded guilty to causing the death of Leah Barnes. The analysis in this Overview Report is therefore firmly underpinned by a belief that Leah's fatal injuries were deliberately inflicted by her Father.

1.2.7 This Overview Report will describe what the Serious Case Review revealed about a failure to discover or take into account the troubled background of Mark Dennis when providing universal services, difficulties in respect of inter-agency communication and information sharing, and in respect of key universal medical services an inability to identify and respond to the significant injuries suffered by Leah. Nothing was ever discovered by professionals about the maltreatment Leah was suffering during her short life, yet as the evidence has been gathered for this review it has revealed that there were opportunities to have done so. Mark Dennis was a violent and troubled father and there were many signs that his troubles worsened due to the injuries which he received whilst serving in Afghanistan. There were clear indicators which, had they been properly shared, should have led professionals to be very concerned about the safety of Leah Barnes.

1.2.8 The Overview Report will also identify some good practice by agencies and professionals and offer recommendations for action to improve the services offered to children and families.

2. Process of the Review

2.0.1 Northamptonshire Safeguarding Children Board (LSCBN) has established a Serious Case Review Committee with responsibility for ensuring that LSCBN undertakes Serious Case Reviews in accordance with government guidance set out in *Working Together to Safeguard Children*. Their function is also to review cases of concern and advise the LSCB Independent Chair of the potential need to conduct a Serious Case Review. The Independent Chair will sign off any review and the Serious Case Review Committee will take responsibility for coordinating and monitoring multi agency arrangements for undertaking and publishing SCRs, and for monitoring the progress of the Action Plan resulting from such a review.

2.0.2 After Leah died, the case was referred to the Serious Case Review Committee on 6th December 2012 by Northamptonshire County Council Adults and Children's Services Specialist Looked After Service. Initial

information requests were sent to all agencies on 20th November 2012 and this information was discussed alongside the referral form at the Serious Case Review Committee on 6th December 2012. The committee also heard information regarding the police investigation into the death and that the father had been arrested. The committee felt that the case met the criteria for a mandatory SCR as set out in Chapter 8 of *Working Together to Safeguard Children* (2010).

2.0.3 The formal recommendation for Serious Case Review was made to the LSCBN Independent Chair on 17th December 2012. Her decision to conduct a Serious Case Review was notified to LSCBN on 23rd December 2012 and was notified to DFE on 24th December 2012.

2.0.4 Concern has been expressed that a Serious Case Review was not triggered by the serious injuries being discovered in May 2011. It is certainly the case that a delay of many months may have limited the amount of analytical information available to the SCR Panel, particularly, when such information is reliant upon the memory of the professionals concerned with the case.

2.0.5 Two independent people were identified and commissioned to lead the review (see below). The Independent Chair was appointed on 25th January 2013 and the Overview Report Author on 23rd January 2013 respectively. This delay was due to seeking advice from with the National Association of Independent LSCB Chairs regarding identifying an Overview Author with suitable experience of working with the Armed Forces. There was also a delay in identifying appropriate SCR Panel membership from the Armed Forces, and their agreement to participate in the Panel was confirmed on 25th February 2013. The timescale for completing the SCR has therefore been adjusted accordingly. The terms of reference were agreed by the Independent Chair on 21st May 2013. The first meeting between those people and representatives from the LSCB took place on 27th April 2013 when draft Terms of Reference and appropriate membership for the SCR Panel were considered. An IMR Authors briefing day was held on 11th May 2013 and the first full SCR Panel meeting was convened on 22nd June 2013.

2.1 The Statutory Basis for Conducting a Serious Case Review

2.1.1 The role and function of a Local Safeguarding Children Board is set out in law by *The Local Safeguarding Children Board Regulations 2006*,

Statutory Instrument 2006/90. Regulation 5 requires the LSCB to undertake a review where –

(a) abuse or neglect of a child is known or suspected; and

(b) either –

(i) the child has died; or

(ii) the child has been seriously harmed 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.

2.1.2 This process is known as a Serious Case Review, and at the time of commencement of this review the procedures for carrying out the review were prescribed in Chapter 8 of the statutory Government guidance, *Working Together to Safeguard Children (2010)*. The product of the Review, known as the Overview Report, is sent to the Secretary of State for Children, and scrutinised by DfE officials. All reviews of cases meeting the SCR criteria must result in a report which is published.

2.1.3 Revised *Statutory Guidance on Learning and Improvement* published by the Department for Education as a consultation draft in June 2012, prescribes that SCR reports should be written with publication in mind and should not contain personal information relating to surviving children, family members or others. This includes detailed chronologies, family histories, genograms, or information known to organisations about the child and family members. Where possible this Overview Report has been prepared within the spirit suggested and, whilst ensuring any lessons are learnt, every effort has been made to minimise distress for family members. Personal information about life within this family has been kept to the minimum required to provide a thorough and meaningful report into this review, although my analysis of practice benefited from a great deal of more detailed information contained within the Individual Management Review reports, which are listed below.

2.1.4 The purpose of the SCR procedure is to

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;

- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

2.2 Independence

2.2.1 To ensure transparency, and to enhance public and family confidence in the process, The LSCB Chair appointed two independent people to lead the Serious Case Review.

2.2.2 In his document *Protection of Children in England: A Progress Report* Lord Laming (2009) expressed the view that in carrying out a Serious Case Review, it is important that the chairing and writing arrangements offer adequate scrutiny and challenge to all the agencies in a local area. For this reason, the chair of an SCR panel must be independent of all of those local agencies that were, or potentially could have been, involved in the case.

Mr. Kevin Harrington, JP, BA, MSc – Independent SCR Panel Chair

2.2.3 Mr Harrington was appointed to chair the Serious Case Review Panel formed to oversee and manage the review process in this case. He was the lead person for ensuring a robust and transparent review was carried out within each relevant agency, and for ensuring that the business management plan and timescales were strictly adhered to.

2.2.4 He has had no involvement directly or indirectly with the child or any members of the families concerned or the services delivered by any of the agencies.

2.2.5 Mr. Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003, he has worked as an independent consultant to health and social care agencies in the public and voluntary sectors.

2.2.6 He has a particular interest in the conduct of Serious Case Reviews in respect of children and vulnerable adults and has worked on over 40 Serious Case Reviews, both providing independent leadership for Reviews

and writing Review reports. He has written three recent reports which have been evaluated by Ofsted as “outstanding”.

2.2.7 Mr. Harrington is extensively involved in professional regulatory work. He has been a Fitness to Practice Panelist for the General Medical Council and for the Nursing and Midwifery Council. He has worked as an Associate to the Parliamentary & Health Services Ombudsman. He has also served as a magistrate in the criminal courts in East London for over 15 years.

Dr John Fox MSc, PhD – Independent Overview Report Author

2.2.8 Dr Fox was responsible for drawing together all elements of the individual agency reviews and for obtaining as much relevant information as possible from family members and significant others who might provide useful learning. He was responsible for analysing the professional practice of professionals and organisations and making recommendations to the LSCB for further action to better safeguard children.

2.2.9 He has had no involvement directly or indirectly with the child or any members of the families concerned or the services delivered by any of the agencies. He has never worked for, or been affiliated with, any agency in Northamptonshire.

2.2.10 Dr Fox is a Senior Lecturer at the University of Portsmouth and previously was a police officer for 31 years including 8 years as a Detective Superintendent and Head of Child Abuse Investigation in the Hampshire Police. He sat as a member of 4 LSCBs and was Vice Chair of Hampshire ACPC.

2.2.11 He represented the Association of Chief Police Officers on various Government working parties and committees, concerning child abuse and related issues, including the drafting of the *Working Together to Safeguard Children* documents (1999, 2006, and 2013) and *Achieving Best Evidence in Criminal Proceedings*, and had the ACPO lead portfolio role for Childhood Death and Forensic Pathology. He was appointed as the Police Service representative to Baroness Helena Kennedy’s Intercollegiate Working Group on childhood death and was Lord Laming’s police advisor and assessor, on the Victoria Climbié Inquiry.

2.2.12 He has previously chaired Serious Case Review Panels, and is regularly commissioned as Overview Report Author by LSCBs. During the period when Ofsted were evaluating SCRs, all his reports were graded as

'outstanding' or 'good.' In 2009, he conducted secondary evaluations, and provided reports as Independent Author, concerning 4 Serious Case Reviews that had earlier been considered 'inadequate' by Ofsted and the Welsh Assembly Government. He has recently carried out reviews using both SCIE and SILP systems methodology.

2.3 Individual Management Reviews

2.3.1 "The aim of agency reviews should be to look openly and critically at individual and organisational practice to see whether the case indicates that improvements could and should be made, and if so, to identify how those changes will be brought about." (Working Together to Safeguard Children 2010)

2.3.2 The Government guidance requires that those conducting agency reviews of individual services should not have been directly concerned with the child or family, or given professional advice on the case, or be the immediate line manager of the practitioner(s) involved.

2.3.3 The people conducting the individual agency IMRs for this Review were all approved by the Serious Case Review Panel and the Independent Author, as being senior personnel within each agency who were completely independent of any involvement or line management responsibilities concerning the case. On 11th May 2013, the IMR Report Authors were offered a briefing as to their responsibilities by the Overview Report Author and SCR Panel Chair.

2.3.4 The Serious Case Review Panel decided that the following agencies and organisations would be asked to contribute to the learning of this Review.

Individual Management Report provided by:
Northampton General Hospital NHS Trust
NHS England Hertfordshire and South Midlands Area Team - Primary Care GP
Northamptonshire Police

Nene and Corby CCGs on behalf of CCGs and NHS England (Health Overview Report)
Armed Forces (compiled by Royal Military Police)
Northamptonshire County Council's Children, Customers and Education Directorate

Factual Report provided by:
East Midlands Ambulance Service
Selly Oak Hospital

2.3.5 The LSCB provided each IMR report author with a template to assist in the writing of their reports, and this was successful in achieving standardisation and consistency, as well as ensuring that the reports focussed on the areas required by the Terms of Reference. Each IMR Author was invited to present their report to the SCR Panel where any clarification was provided, or additional work requested. In addition to this, where necessary I had direct contact with members of the IMR Team in order to best inform my analysis in this Overview Report.

2.3.6 It was noted by Ofsted (2010) that the duties of the Overview Report Author, include, 'challenging the quality and content of individual management reviews and ensuring that the overview report compensates for any identified deficiencies.' Collectively, the quality of the IMR Reports was sufficient for me to understand the case and provide an analysis of most of the issues I felt were significant. The report by the Armed Forces was particularly comprehensive and contained robust analysis. It is likely to be rare that the Armed Forces are asked to contribute to a Serious Case Review and the structure and content of this particular IMR should be considered as a good example to draw from in the future.

2.4 The SCR Panel

2.4.1 The dedicated Serious Case Review Panel met five times prior to the presentation of the Overview Report. The general management of the SCR Panel meetings was efficient and effective.

2.4.2 The Independent Panel Chair was assisted by the LSCBN Standards, Research & Development Manager as well as an administrative support officer at most meetings.

2.4.3 I was invited to attend the meetings of the SCR Panel. The Panel provided me with good advice and constructive comments about this Report and they were effective in ensuring most IMR Reports were as full and robust as possible.

2.4.4 Panel membership was as follows:

Kevin Harrington	Independent Chair of Serious Case Review Panel
Chair	LSCBN SCR Committee
Detective Chief Inspector	Northamptonshire Police
Associate Director of Nursing	Northampton General Hospital
Designated Doctor for Child Protection	CCG's and NHS England
Major	Royal Military Police
Joint Chief Executive	Northampton Women's Aid

2.5 Terms of Reference

2.5.1 The review covered the period from 1st January 2009, when Leah's mother was known to pregnant with her first child Keifer until 7th November 2012.

2.5.2 The full Terms of Reference (ToR) can be found at Appendix A.

2.5.3 The ToR were ratified by the LSCBN Independent Chair on 21st May 2013, and thereafter became the instructions to the two independent people about the scope required for the Review.

2.5.4 The ToR specified 8 key issues in this case together with a requirement that these issues *'require particular analysis'* within the Overview Reports.

2.6 The Voice of the Children, Family and Significant Others

2.6.1 A commitment to providing the fullest opportunity for individuals with a close connection to the family to be invited to participate in the reviews was agreed at the first panel meeting. It was agreed that Leah's mother, father, and maternal and paternal grandparents should be approached.

2.6.2 The SCR Panel Chair wrote to the family members in January, March and May 2013 requesting consent for information to be gathered and to arrange a meeting with the independent reviewer. The letters were written using sympathetic, jargon free terminology and a sample is attached at Appendix B.

2.6.3 As discussed earlier, there is a parallel police homicide investigation into the death of Leah. In accordance with Paragraph 8.25 *Working Together to Safeguard Children* (2010), the Overview Report Author made contact with the police Senior Investigating Officer (SIO) to discuss whether and how the SCR process might have a bearing on his investigation. It was explained to the SIO that the intention was to seek a contribution from the parents by way of a formal discussion. After obtaining a view from the Crown Prosecution Service the SIO raised no objection, subject to certain safeguards which the Overview Report Author was happy to comply with.

2.6.4 Leah's mother declined to meet a reviewer but an arrangement was made for the Overview Report Author and another Panel member to meet both Leah's father and Leah's paternal grandparents at their home on 16th May 2013 in order to seek a contribution to the learning for the SCR. The meeting took place at the family home and present were Mark Dennis, his mother and his father.

2.6.5 It is noteworthy that despite the fact that both Leah's parents had been arrested and her father charged with murder, the SIO was extremely helpful in supporting the needs of this Review. As described above he was contacted by the Independent Overview Report Author and asked for his view as to the timing of any conversations with the parents

and after a discussion with the Crown Prosecution Service he wrote back agreeing to the meeting with the parents subject to a request for access to any notes from the conversations. The SIO also provided the SCR with some valuable information gathered during the homicide investigation. In general terms, this was a very good example of how a Serious Case Review and parallel criminal proceedings can operate alongside each other in a mutually beneficial way.

2.7 Individual Needs

2.7.1 The guidance in *Working Together to Safeguard Children* requires consideration to be given to individual needs - racial, cultural, linguistic and religious identity – of the child who is the subject of a Serious Case Review.

2.7.2 Leah and her parents are white British and there is no information within any case files that the family had any religious beliefs, although just before her death Leah was baptised at the request of her mother and maternal grandparents. There was no evidence in the material that any issues of race, religion, language or culture affected events in this case or should have been significant in influencing the practice or approach taken to the delivery of services.

2.7.3 There is no evidence of poverty within the household, although the GP IMR Report noted that Leah lived in one of the more deprived areas of Northampton.

2.7.4 There were comments made in the medical notes that Leah's mother had support from her extended family which suggests that she was continuing along her cultural normal pattern of social integration. There is no evidence in education or health records to suggest that this family experienced social or any other form of exclusion.

2.8 Accountability for the Overview Report

2.8.1 I have attended meetings of the SCR Panel and the briefing day arranged for the IMR Report Authors.

2.8.2 Whereas I am accountable for the content and analysis within this Overview Report, the members of the SCR Panel have contributed to the process of the preparation and have offered helpful comments and

suggestions during the drafting process. A particular issue which caused a divergence of views within the SCR Panel is the matter of Leah's 6 week health visitor/medical check up. This is dealt with as a key episode in Section 5.3 below.

3. The Facts - Summary of agency involvement

Source

This section is designed to summarise the key relevant information that was known to the agencies and professionals involved about the parents, and the circumstances of the children.

3.1 Della Barnes' early years

3.1.1 Della Barnes was born in 1992. Little is known about her early childhood.

3.1.2 There are no notes of significance from her childhood in the NGH archived records.

3.2 Mark Dennis' early years

3.2.1 Mark Dennis was born in 1988.

GP Records

3.2.2 In October 1988, a referral was made for 'failure to thrive'.

3.2.3 In February 1989, Mark Dennis was presented to hospital with spiral fracture of the femur when he was 10 months old. This was felt to be non accidental in origin and he was placed into foster care and during the first 5 years of his life, most of this time his name was on the child protection register.

Police IMR
NGH IMR
GP IMR

3.2.4 As described later in this report, there is evidence that in his first few years of life he experienced unhappiness and tension at home, and was undoubtedly a child who suffered significant harm at the hands of his carers. Apart from the physical injury, he also suffered weight loss, believed by a paediatrician to be 'social in origin' or in other words due to neglectful parenting.

GP IMR

3.2.5 In 1996, when aged 8, Mark Dennis, was showing several signs of emotional distress and he was referred to the Child and Family Consultation Service.

GP IMR

3.2.6 He enlisted into the Army in January 2005 and following his basic training, he joined the Grenadier Guards, with whom he served for eight years.

RMP IMR

3.2.7 Whilst serving in the Falkland Islands on 5 April 2008, Mark Dennis was investigated for an incident of alleged violent disorder and assault occasioning actual bodily harm. No further action or prosecution was taken.

RMP IMR

3.3 The Relevant Period of the Review

3.3.1 Della Barnes booked with maternity services at Northampton General Hospital (NGH) for her first pregnancy in October 2008. She reported that she was living at her sister's address and gave her mother's name as next of kin. She did not give a name for the baby's father and said that she was not in a relationship. Della attended all antenatal appointments and received expected care. Staff recorded that she was well supported by her mother, Lisa Ilworth-Barnes, throughout the pregnancy. No safeguarding or other welfare concerns for Della or the unborn baby were identified during the pregnancy.

HOR

3.3.2 On 19th May 2009, Della Barnes attended an appointment with the Midwife at her GP surgery at 38 weeks of pregnancy. It was documented that all was well and that *'Mum was looking forward to the birth'*.

NGH Notes

3.3.3 On 28th May 2009, Keifer was born. The delivery was uncomplicated and no abnormalities were detected. Two days later, Keifer and his mother were discharged home.

NGH Notes

3.3.4 On 8th June 2009, a postnatal visit to Keifer was conducted by a midwife. He was seen to be sleeping, and there were no concerns. However, it was documented that Della was experiencing problems with ex-boyfriend (presumably Mark Dennis). The Midwife advised Della and her mother to seek advice from a solicitor.

NGH Notes

3.3.5 On 11th June 2009, Mark Dennis made an application to the courts for parental responsibility in respect of Keifer (which was granted in July 2009). A week later on 18th June 2009, a Police Officer submitted a 'Threat Danger Report' on intelligence system. The reason related to a dispute between Mark Dennis and Della Barnes over visiting rights for Keifer. The report stated that, '*Della and her mother are concerned that the Dennis family are trying to take Keifer from her.*' Notes in the CAFCASS file record that Della Barnes alleges that Mark Dennis was violent to her. She describes him as '*a bully and frightening.*'

CAFCASS Chron

Police IMR

3.3.6 Whilst serving in Afghanistan, Mark Dennis was seriously wounded in action on 3 November 2009 and evacuated to UK. He then continued a detailed programme of care and rehabilitation set by military doctors. For reasons which are unclear, Mark Dennis re-registered with his family General Practitioner in 2009. Normally, a serving soldier should not be registered with a 'civilian' GP, but the GP visited him at his parents' home on 22nd December 2009 and noted he was injured to such an extent that 'would affect the self image of a young man'. The GP recalls that he was "pretty sure" he had broached the subject of post traumatic stress disorder and he feels that Leah's father replied that the Army would provide anything he needed and that there was no specific health need declared.

RMP IMR

GP IMR

3.3.7 On 5th March 2010, Della Barnes took Keifer to hospital and he was admitted as a paediatric in-patient with fever, lethargy and petichial rash. He was well enough to be discharged home the following day.

NGH Notes

3.3.8 During March 2010, CAFCASS became involved with the family as a result of the visiting rights dispute between Della Barnes and Mark Dennis.

Care First Records

3.3.9 During rehabilitation admission to a specialised medical centre in April 2010, it was described that Mark Dennis had begun to have some Post Traumatic Stress (PTSD) symptoms and was feeling irritable, although the rating scales used did not reflect high scores for depression or anxiety. It was commented about him developing mood/anger symptoms. During these

RMP IMR

consultations there was no mention of any family issues nor had he informed staff that he had a child.

3.3.10 In June 2010, Whilst Mark Dennis continued his rehabilitation in his Unit, it became apparent that his behaviour was erratic and ill-disciplined and that he had issues with anger. A number of meetings were held with Unit Welfare Officer, the Military Doctor, his superior Officers and Occupational Health therapist to address his continued lack of engagement and employment. The unit were also aware that he was being seen by his Military Doctor and Psychiatric Nurse (CPN) to address the issues.

RMP IMR

3.3.11 On 1st August 2010, the GP became aware that Della Barnes was pregnant as she attended the surgery complaining of early pregnancy bleeding. The pregnancy was confirmed on 4th August 2010 after an ultrasound scan.

GP Records

NGH Notes

3.3.12 On 2nd August 2010, Mark Dennis had a conversation with a doctor employed by the Army during which he talked about problems controlling his anger and specifically, his fears that he might hurt his 14 month old son.

RMP IMR

3.3.13 On 23rd August 2010, Della Barnes attended an appointment with a Midwife and a full social and medical history and risk assessment was completed by the midwife. Her status was recorded as 'single'. No details were given regarding the baby's father other than he was British European. The next of kin was given as Della's mother. A standard question regarding domestic abuse was not asked as client not seen alone.

NGH Notes

3.3.14 On 26 August 2010, a Consultant Psychiatrist 1 within the Department of Community Mental Health, Woolwich held his initial consultation with Mark Dennis. Psychiatrist 1 recorded that he had, '*anger issues, has always had a quick temper, but now gets angry at the slightest issue and will overreact, as examples he decided not to see his 14/12 son alone as he was losing temper with him, anything at work can set him off, way people look at him, road rage etc. Is getting physically aggressive though never with son or family*'. His family history was recorded as, '*son live in Northampton with his mother, [Mark] also has house in*

RMP IMR

Northampton and sees son as often as he can'. Psychiatrist 1 concluded Behaviour Therapy (anger management) was indicated and he would look at his previous experiences in Afghanistan to see if he could make links to present anger problems.

3.3.15 The Consultant again saw Mark Dennis on 16 September 2010. It was noted that Mark Dennis discussed five episodes of anger since his last appointment; however, no further detail is recorded.

RMP IMR

3.3.16 Shortly after 1st October 2010, when his Senior Non Commissioned Officer again addressed his repeated lateness, Mark Dennis 'erupted' and drove himself to the Medical Officer (apparently as he could not cope).

RMP IMR

3.3.17 On 5th October 2010, Della Barnes attended an antenatal appointment with a Midwife at the GP surgery. At that time she was 15 weeks pregnant. No concerns were recorded and on this occasion she was asked whether she had been a victim of domestic abuse but no abuse was disclosed.

NGH Notes

3.3.18 On 3rd November 2010, during an appointment with an Army Community Psychiatric Nurse it was recorded that Mark Dennis has '*had a couple of anger related situations towards girlfriend, snapped at her, grabbed her, threatened to hit her, got upset afterwards.*'

RMP IMR

3.3.19 On 4th January 2011, Della Barnes attended a routine antenatal appointment with a man described in the notes as her 'ex partner'. It is not known if this was Mark Dennis.

NGH Notes

3.3.20 Mark Dennis failed to attend his booked appointments with the Army Medical Services in January and February 2011, therefore, he was discharged from the care of DCMH Woolwich on 8th February 2011. There was no follow up mental health care offered nor are there any records to show that a referral was made back to his Regimental Medical Officer or to his unit regarding his failure to attend the appointments. There is no further recorded Primary Health Care activity until April 2011.

RMP IMR

3.3.21 On 21st March 2011, Della Barnes, accompanied by Mark

Dennis, attended Northampton General Hospital for the birth of Leah Barnes. The baby was delivered at 11.29 hours without complications and was a healthy child. It was noted that '*Baby dressed by dad. No concerns raised during the afternoon.*' It was further documented at 19.00 hours that Mark Dennis has returned to his army base.

NGH Notes

3.3.22 Della Barnes and Leah were discharged home on 23rd March 2011. Nothing abnormal was noted during the two days in hospital after the birth.

NGH Notes

3.3.23 A Community Midwife visited Leah at home on 24th March 2011 for a routine postnatal visit. No concerns were recorded regarding Leah and there was no indication whether Mark Dennis was present in the household.

NGH Notes

3.3.24 Two days later on 26th March 2011, a Community Midwife paid a further visit to Della Barnes on a routine postnatal visit. It was recorded, '*Baby check declined as recently seen and no concerns.*'

NGH Notes

3.3.25 When Leah was a week old, on 28th March 2011, a Midwife weighed her at home during a routine visit. Weight loss of 195g was recorded.

NGH Notes

3.3.26 The following day, Mark Dennis was 'spoken to' by police officers after a report that he had assaulted Della Barnes' mother. It was alleged that a heated argument erupted between herself and Mark which escalated to Mark punching her twice in the chest and pushing her upper body. She also alleged that he had done something similar to her other daughter two years previously which had not been reported to the police. No formal complaint was made and no further action taken. Mark Dennis denied the assault took place. (It is not known what contact, if any, Mark Dennis was having with Leah at this time and there is very little mention of him in any medical notes.)

Police IMR

3.3.27 On 4th and 5th April 2011, a Health Visitor attempted to meet the family at home in order to begin the process of taking over the care from the midwifery service. On both those days, the Health visitor got no reply, but she did carry out a successful

NHFT Notes

primary visit on 6th April. It was recorded '*Leah seen with mum Della. Alert and active appeared well.*' It was also noted that Della Barnes was now '*back with*' Mark Dennis. Della reported that the relationship was '*ok but has difficult moments*'. It was not recorded whether Mark Dennis was present at the time of this visit or how often he was present within the household, but the Health Visitor was told that the couple do not live together. The Health Visitor was also told that Mark Dennis had suffered serious injuries whilst serving with the Army in Afghanistan.

Leah was 17 days old

3.3.28 Between 6th April and 3rd May 2011, Leah was not seen by any health professional. The Health Visitor made 4 attempts to contact the family by telephone on 19th, 20th, 26th and 27th of April, but each of these calls was unanswered.

NHFT Notes

3.3.29 On 29th April 2011, Della Barnes attended A&E complaining of back pain and abdominal pain. There is no record of her being asked about possible domestic abuse and Leah was not present during the visit. Analgesia was given together with advice for a GP follow up.

NGH Notes

3.3.30 On 3rd May 2011, Leah was seen by a Community Nurse for a 6 week check up. It is not clear where the examination took place. It was recorded that '*baby appeared well and alert*'. It was noted that Leah had only gained a pound in weight since the primary visit and had dropped to the 9th centile. This is lower than should have been expected but no action was taken regarding this small weight gain other than an arrangement to weigh Leah again in 3 to 4 weeks. Leah's mother was asked about her emotional health but said she didn't need any help. Nothing further was discussed about the relationship and input from Mark Dennis or how often he is home and how he copes with Children.

NHFT Notes

3.3.31 The following day, Leah was taken to the GP surgery by Della Barnes and they were seen by a Health Visitor. Della Barnes was concerned that Leah was not well as she had not put on much weight. It was recorded '*Leah awake appeared alert, appeared slightly pale*'. (Note: It is now clear that there is a strong likelihood that Leah had suffered severe injuries by this time in

NHFT Notes

her life).

3.3.32 8th May 2011, Leah Barnes received the injuries which immediately precipitated her collapse. Initially one of her parents contacted the out of hours GP service, NeneDoc, describing Leah as unrousable and cold. Advice was given to dial 999. Leah was taken to NGH Accident and emergency department on the 8th of May at 17.15 hours by her parents. The injuries Leah sustained were extensive and were summarised as followed by the registrar to Consultant Paediatrician:

- Non accidental injury
- Hypoxic Ischaemic Encephalopathy (Brain trauma)
- Epidural blood collection in lower thoracic/lumbar region
- Left sided parietal skull fracture
- Multiple retinal haemorrhages
- Thoracic vertebral fractures (Spinal fractures)
- Multiple rib fractures
- Right Humeral fracture
- Hepatomegaly, (Liver damage)
- Diabetes Insipidus

3.3.33 The interagency referral form completed by NGH staff indicated that at 17.30 hours hospital staff alerted Children's Social Care, who in turn notified the police of Leah's condition. The initial report to the police control room was received at 21.14 hrs from the duty social worker. Police officers were deployed to an address where officers are told Keifer is being looked after, and at 22.03 hours a Detective Chief Inspector arrived at the hospital to lead the police investigation. He placed Leah in Police Protection and arrested both parents.

3.3.34 Leah was transferred to the specialist paediatric intensive care unit at Oxford Radcliffe hospital on the same evening where she remained until 23rd May 2011. She was then transferred back to NGH for a while and when all hospital treatment had been exhausted she was released into the care of her Maternal Grandmother on 24th July 2011.

3.3.35 From the time of her injuries being identified until her death Leah struggled with epilepsy, pain, feeding difficulties, and

GP IMR
HOR
NGH Notes

NGH Notes
Police IMR
HOR

HOR

NGH Notes

constipation. Due to the brain damage and associated retinal damage Leah could barely see and therefore her sensory awareness visually was very limited. Leah also required hand splints as due to the brain damage she had a level of spasticity in all limbs which led to her fingers rubbing into her palms.

3.3.36 Care proceedings were initiated in respect of Leah and Keifer with them becoming subject to Interim Care Orders, S.38 Children Act 1989, on 6th June 2011. Leah and Keifer were Looked After Children until a Special Guardianship Order was made in respect of both children in favour of maternal grandparents, Oliver and Lisa Barnes, in July 2012.

CSC IMR

3.3.37 Leah's condition deteriorated and she died on 7th November 2012 at Rainbows Hospice.

CSC IMR

3.3.38 Mark Dennis was discharged from the Army in April 2013.

RMP IMR

4. A Day in the Life of Leah and her Family

4.01 Before her significant injuries were discovered, Leah lived with her mother in a flat in a quiet residential area.

4.02 It is evident that her main carer was her mother but her father was also present in the household at weekends. Information that was shared with nurses post the non-accidental injury reveal that Leah was in an environment where domestic abuse was perpetrated. It is not clear what episodes of domestic abuse, if any, she witnessed or heard.

4.03 After her admission to A&E with significant injuries Leah was a very sick child with many irreversible health related problems. She was in pain, with a poor swallow reflex and seizures with the need for around the clock care. Upon leaving hospital, Leah lived with her maternal grandparents until shortly before her death when she moved to a hospice.

5. Analysis of Practice and the Lessons Learnt

5.0.1 Issues which have been identified as requiring particular analysis in respect of the circumstances of this case are:

- It is a matter of concern that this case was not referred to Serious Case Review Committee following the serious and life threatening injuries sustained by Leah on 8th May 2011. The reasons why this did not happen will be addressed by the Overview Author together with any actions subsequently taken or required to prevent a similar occurrence in future.
- The way in which agencies work together to identify concerns, share information and support armed service personnel living in localities and accessing a range of services across local authorities.
- What efforts were made by agencies to access information held by the armed services in relation to Leah's father's physical and mental health?
- To assess the impact of Leah's father's physical health, mental health and the apparent domestic violence on Leah's parents' ability to safely parent Leah and Keifer and any potential risks that his contact with the children may have posed
- What relevant historical information prior to Leah's birth was known to the agencies about the background and experiences of Leah's parents? Was this information effectively shared to ensure that appropriate decisions could be made to ensure she was protected from any known risks?
- Did the professionals working with Leah and her family have the required knowledge, skills and experience regarding the identification of and required response to possible child abuse and domestic violence? Were there any gaps in practice that may have impacted upon the outcomes for Leah?
- Children's Social Care to consider how the extended family's view of family functioning was used in their assessments and risk analysis.

- With hindsight what, if anything, could have been done differently and what impact, if any, such action may or may not have had on the outcomes for Leah?

5.0.2 Each of these key issues is considered later in this section but the headline result of the analysis of the available information is that although it is now known that Leah was probably carrying serious injuries for a significant part of her life, this Serious Case Review has revealed no evidence that any agency or individual discovered those injuries or expressed any specific concerns for Leah's developmental milestones, health, wellbeing or upbringing. As a child she was 'visible' in the sense that she was seen appropriately by midwives, health visitors and her GP, as well as extended family. There had been no safeguarding or 'child in need' referrals from any third party to children's social care and Leah had never come to the notice of the police. No injuries to Leah or physical signs of neglect which could reasonably have necessitated a safeguarding referral to Children's Social Care were noticed or recorded by any professional.

5.0.3 When Leah was admitted to A&E on the 8th May 2011, the medical care and safeguarding response by NGH doctors, nurses and other staff was excellent. Leah was attended to by the paediatric arrest team under the care of a consultant paediatrician and this is the appropriate level of input. All relevant investigations were carried out including radiology for CT scan of the head, pathology for full blood works, full skeletal x-rays and ophthalmology assessment. Doctors quickly and unambiguously recognised this as a case of non accidental injury and promptly alerted Children's Social Care who in turn contacted the Police. Leah's parents were treated with respect and given appropriate support by hospital staff.

5.0.4 The interagency referral from NGH to Children's Social Care was completed and sent at 17.30 hours and the police arrived at 22.30 hours. It is a matter of concern that the police did not arrive at NGH until 5 hours after Leah's admission, but the Police Control Room did not receive notification from Children's Social Care until 2130 hours so the delay appears to have been as a result of the failure by Children's Social Care to promptly pass on the referral from the hospital.

5.0.5 Evidence presented to the current review indicated that during a recent Ofsted inspection the Northamptonshire Children's Social Care Out of Hours Service was criticised because of *'weak out of hours responses to*

safeguarding concerns and poor recording'. It is noted that several measures have been put in place since that inspection to improve the Out of Hours response, and had they been in place at the time, these measures may have prevented the deficiencies when Leah was referred. However, to further seek to avoid a situation in future whereby a hospital referral which needs police attention is not passed on promptly by Children's Social Care, it was the view of the SCR Panel that when children are presented with suspected non accidental injuries, (which by definition means a crime is at least suspected), the hospital staff should make referrals to both Social Care and the Police. The LSCBN Child Protection Procedures should be amended to require this.

RECOMMENDATION 1

5.0.6 The police response on the 8th May 2011 was led at an appropriate level by a Detective Chief Inspector, who was a trained Senior Investigating Officer (SIO) and the criminal investigation was commenced without delay and conducted to a high standard. Urgent steps were taken by a Detective Sergeant to trace and see Keifer, and after some obstruction by his grandparents, he was successfully checked by the police officer and a social worker. The urgent consideration given to checking the welfare of Keifer together with the tenacity in discovering his whereabouts was good practice by Police and Children's Social Care. The SIO in attendance at Northampton General Hospital directed that Leah be placed in Police Protection under Section 46 Children Act 1989 to prevent her being moved from hospital. Keifer was not placed in Police Protection as, according to police information, the Social Worker was satisfied that he could stay with family members.

5.0.7 Each relevant IMR Reviewer examined closely the medical care and support offered to Leah and her family from the time she arrived with serious injuries at NGH until her death several months later, and a great deal of analysis in their reports is devoted to this period of time. The efforts made to treat Leah and make her life as comfortable as possible were beyond reproach. Likewise, the support given to her family from medical staff and social workers was considered to be excellent, although the NGH IMR Report raised concerns that at times medical staff experienced some difficulty in getting information from Children's Social Care about issues of parental responsibility etc. The excellent working arrangements between NGH staff and Rainbows hospice ensured that Leah's palliative care and end of life needs were met in a sensitive and compassionate manner.

5.0.8 The key issues with which this review is concerned are whether any signs of injury to Leah may have been missed by any professional who had contact with her, or whether any information which was either known about her parents, or available but not accessed, should have triggered further enquiry before her birth or in the first few weeks of her life.

5.0.9 The remainder of this analysis section is constructed to analyse four critical episodes and these are linked to the case specific themes prescribed by the Terms of Reference. This section of the report will examine, in broad terms, whether there was any reasonable possibility that an agency or individual professional could or should have been able to predict that Leah was a child in need of protection.

5.1 Taking Account of Men in the Family

Linked to the following ToR themes:

- **To assess the impact of Leah’s father’s physical health, mental health and the apparent domestic violence on Leah’s parents’ ability to safely parent Leah and Keifer and any potential risks that his contact with the children may have posed**
- **What relevant historical information prior to Leah’s birth was known to the agencies about the background and experiences of Leah’s parents? Was this information effectively shared to ensure that appropriate decisions could be made to ensure she was protected from any known risks?**
- **Were appropriate actions taken by agencies in response to any indicators that Leah might be at risk of significant harm or vulnerable to becoming a child in need?**
- **With hindsight what, if anything, could have been done differently and what impact, if any, such action may or may not have had on the outcomes for Leah?**

5.1.1 An important theme in an earlier Northamptonshire SCR (Child I) was a failure by health professionals to take into account the father of the child, or access relevant information about him. In that case, there was a

reported perception amongst midwives and health visitors that under data protection laws, unless there were specific safeguarding concerns any information relating to the father of a child could not be accessed. The conclusion of that SCR was that this was a misinterpretation of the law, (although it is important to say that the Overview Report into that case had not been published at the time of the events relating to Leah Barnes). In the current case there was also important information about the father, Mark Dennis, available to those working with the family, but it was not accessed and it is important to establish why.

5.1.2 In his 2009 report, Lord Laming firmly reminded us about the role of fathers within parenthood. He stressed, '*parenthood incorporates not only rights but also responsibilities: it is a lifetime commitment. Particular mention should be made of the part to be played by fathers.*' The spirit of this comment seems to be that with fatherhood should come an acceptance that one's own personal rights to privacy will be subordinate to the responsibility that one's child is properly safeguarded. This was also a theme recognised by Brandon et al (2009) in one of the Biennial Analysis Reports of Serious Case Reviews.

The failure to know about or take account of men in the household was also a theme in a number of serious case reviews. Assessments and support plans tended to focus on the mother's problems in caring for her children and paid little attention to the men in the household and the risks of harm they might pose to the children given histories of domestic violence or allegations of or convictions for sexual abuse.

Brandon et al, (2009)

5.1.3 It is correctly noted in the NGH IMR Report that, '*Historical information in relation to the NAI and neglect Mark suffered in his childhood represents considerable risk and had Mark's notes been accessed there is no doubt it would have contributed to the risk assessment*'.

5.1.4 Mark Dennis attended two antenatal appointments with Della Barnes and was present at the birth and for four hours afterwards, before he had to return to his barracks. He was therefore clearly visible to midwives as Leah's father during, and around the time of her birth, but

Della Barnes did not formally declare him as her partner. It is suggested in the NGH IMR Report that, *'...as Della did not declare Mark [midwives] had no reason at that time to access his notes.'* Although, as will shortly be discussed, this statement is incorrect it is informative in as much as it seems that amongst midwives at NGH there is a complete reliance on information that is volunteered by the mother during routine appointments whilst at the same time ignoring that which can be clearly observed.

5.1.5 It is apparently policy within NGH for midwives to treat the mother (and not the father) as their 'client', and it would appear that within NGH a midwife relies only on the details she obtains from the client in answering routine questions. This policy renders the midwife wholly dependent on the mother's willingness to disclose information, which she may be reticent to share. Members of the SCR Panel felt that this report should reflect the fact that this is national rather than local policy and a reference was made to the Midwives Rules and Standards (2012) to support this. In fact, whilst certainly emphasising the relationship between mother and child, that national document also reminds midwives, *'You must make sure the needs of the woman and her baby are the primary focus of your practice and you should work in partnership with the woman and her family'*.

5.1.6 It is accepted that many new mothers may be apparently unattached, or may decide to bring up a child alone, so Della Barnes' decision not to initially disclose the name of Leah's father might not be considered unusual in today's society. However, in this case Mark Dennis was present on several occasions with Leah's mother and after Leah was born it was noted that the baby was 'dressed by Dad' which clearly indicates that midwives knew that he was a parenting figure and it could be suggested that in the spirit intended by the *Midwives Rules and Standards* (2012) that he was part of the woman's 'family'. It would also be clear to anyone meeting Mark Dennis that he had been seriously injured and had some disability. The latter fact could reasonably have led staff to consider whether, if he was to take on parenting responsibility, he might benefit from support.

5.1.7 It is suggested in the NGH IMR Report that it would be very difficult for the midwife to insist on the woman disclosing the name of her partner as this could have a *'negative effect'* on the midwife's future relationship with the woman. It seems clear that Della Barnes did not volunteer much

information, although confusingly, the Health Overview Report includes the comment, 'On 21/03/11 Della was admitted to labour ward and named Mark Dennis as her partner and the father of her baby.' This would indicate that NGH staff were in no doubt that Mark Dennis was a significant factor in Leah's life but still there is no evidence that any proactive attempts were made by midwives to engage Leah's father, work in partnership with him, or generally find out anything about him. This was a missed opportunity, and the learning provided by Mark Dennis and his parents to the current review suggests that he did feel isolated from events and would have been receptive to offers of support from professionals.

5.1.8 Any perception that a midwife cannot make enquiries about the father of a child would be troubling, and it would be contrary to the views expressed by Lord Laming (2009) and Marion Brandon (2009). Although it is accepted that a mother can ultimately choose to remain silent, it seems difficult to understand why it might have a '*negative effect*' on the relationship between mother and midwife for the identity of her partner to be proactively sought. There is no evidence that during his attendance at the antenatal appointment or the birth anyone asked Mark Dennis directly if he would mind giving his name in order that he could be formally identified as the child's father. During the interview conducted to allow Mark Dennis to contribute to the learning for the current review, he indicated that would have been prepared to engage with health professionals but felt that no-one explained the process or gave him antenatal education.

5.1.9 Since the primary, and most vulnerable 'client', in any new birth is actually the baby, it seems unacceptable that the fullest information about all parents or caregivers is not sought with some degree of determination. It is the view of the Health Overview Report Author that at the time of booking for the birth of Leah, active enquiries should have been made about her father with a view to at least finding out his full identity. Even if this information is not gathered at the time of booking, active steps by midwives should be taken to acquire it during the antenatal or birth period. If a father is not visible at all during the process and the mother declines to identify him then that fact should be clearly noted. **RECOMMENDATION 2**

5.1.10 In terms of assessing whether a father might be a risk to a child it is a prerequisite to at least know his identity, but it might also be argued

that it is important to check whether anything is immediately known about him which might heighten concerns. In this case even if Leah's father's identity had been sought by, or disclosed to midwives, the evidence gathered for this review indicates that his background history would not have been routinely accessed anyway.

5.1.11 Although there was no suggestion in the NGH IMR Report that in the current case under review it was concern over data protection legislation which prevented information being accessed by midwives at NGH, as described earlier this was a factor identified by the SCR concerning Child I which dealt with events in close temporal proximity to Leah's birth. It is therefore worth re-emphasising that data protection laws rarely, if ever, prevent professionals from accessing information which could help safeguard children. Unlike the situation revealed during the SCR concerning Child I, the reason for not accessing a father's notes in the current case is partly explained in the NGH IMR Report thus: *'The childhood history was in archived childhood notes these are not routinely accessed unless there are safeguarding concerns, as it would demand a considerable administration resource.'* Within NGH, childhood notes are archived off site and are not routinely referred to when adults access adult services such as midwifery. However if, safeguarding concerns are raised then archived notes can be accessed if felt appropriate but in this particular case midwives did not identify any reason to access Mark Dennis' notes. The flaw with this is that, as Lord Laming pointed out in the Victoria Climbié Inquiry Report (Laming, 2003), *'child protection cases do not always come labelled as such'*, so the problem with a system which relies upon concerns being raised before relevant information is accessed rather misses the point that it might only be by checking the information that any safeguarding concerns become apparent.

5.1.12 Some members of the SCR Panel felt that it is not a question of administration resourcing issues, but more likely that the culture is such that a father's records would not be checked anyway, and indeed, that it would be disproportionate to routinely check the known medical records of all fathers of children. This is a reasonable viewpoint but because in this case the father was clearly coping with a serious disability it is highlighted by all the health sector IMR Reviewers that it would have been desirable, and of great relevance, for professionals to have known more about Mark Dennis.

5.1.13 As will shortly be explained, there were different sources of information available to midwives. For example, the Health Visiting service had earlier received important information about Mark Dennis, and his violent disposition, at the time of Keifer's birth, and this was included in the notes held by Leah's GP. Laming (2009) pointed out that *'children can only be protected effectively when all agencies pool information, so that a full picture of the child's life is better understood.'* There is no legal barrier to the gathering or sharing of information about a father. *'The safety and welfare of children is of paramount importance, and agencies may lawfully share confidential information about the child or the parent, without consent, if doing so is in the public interest'* (Laming, 2009). There is no need for there to be a safeguarding or child protection concern to allow information sharing between professionals; a *'public interest'* has been interpreted (Laming, 2009) as simply being *'the promotion of child welfare.'*

5.1.14 In this particular case, had the information been sought, agencies, including the GP, Police and Children's Social Care, held a great deal of information about Mark Dennis which would have revealed his own troubled childhood, and perhaps caused questions to be asked about his suitability for fatherhood. The NGH IMR Author made the assessment, *'The effects on Mark's long term development from a combination of domestic abuse, non-accidental injury and neglect as evidence by the non-organic failure to thrive cannot be under estimated.'*

5.1.15 In the NHFT IMR Report, the author accurately describes how Mark Dennis, *'appeared to fall within the concept of the 'Shadowy Male' where professionals know about the male presence but little is known about his involvement, his history and his role within family life.'* Had it been accessed or sought, the significant information about him which was potentially available to those professionals working with the family can be summarised thus:

- On 6th October 1988, when he was 6 months old, referral regarding 'failure to thrive'.
- He had a number of contacts with Children Services.
- On 10th February 1989, presented to hospital with spiral fracture of the femur when he was 10 months old. This was felt to be non

accidental in origin and he was placed into foster care. Both parents arrested on suspicion of causing GBH to Mark Dennis.

- CP Conference held 1st March 1989, Mark placed on the 'at risk register' and placed in foster care. In the conference report Mark was described as: "*A neglected little boy receiving very few positive responses from his mother, his mother has very little time for Mark and very little patience.*"
- On 10th September 1989, Mark Dennis was placed back with his mother and father but medical check in December 1989 revealed, 'Weight still just below 3rd centile. Height 50th, head circumference 50th. Appeared extremely miserable.'
- Mark Dennis was referred to the local consultant paediatrician because of weight loss. He was then admitted to the paediatric ward for observation. He stayed in the ward for one week and it was observed that his weight started to increase. The diagnosis of the paediatrician was that the weight loss had been of "social origin".
- 10th January 1990, Child Protection Conference held. Mark Dennis remained on Child Protection register. His sister to be placed on child protection register under category of grave concern. Mark Dennis was on the child protection register from 1989 to 1992. This means that he had significant child protection concerns for the first 5 formative years of his life. He was eventually taken off the child protection register in 1992.
- On 17th May 1990, Mark Dennis was admitted to hospital for 'weight loss and diarrhoea'.
- On 23rd October 1990, aged 2, Mark Dennis was again assaulted by his parents. This came to light when the Nursery which Mark attended saw that he had bruises which had been a result of over chastisement by father. Parents were interviewed by police and his father was charged with assault.
- GP's notes reveal that in 1996, there was a consultation with Dr Hewitt detailing issues over Mark Dennis' behaviour. He was stealing, bed wetting, soiling and demonstrating encopresis which

are all signs of emotional distress. He was referred with his family to the Child and Family Consultation Service.

- On 11th March 1999, Mark Dennis' medical records indicate that he was admitted to hospital due to a 'Greenstick fracture of distal radius'.
- Through the rest of his childhood Mark Dennis' medical records indicate there were several minor injuries including fractures of a finger and toe when it was reported that he punched a hard object and was knocked over in a road traffic accident.
- On 19th December 2003, Mark Dennis was referred to SC&H and to CPU for welfare concerns as it was believed that the children were being left with unsuitable adults.

5.1.16 Other environmental factors which may have been taken into account would include:

- The father appears not to have been present at some antenatal appointments and little was known about him.
- He was suffering from visible serious injuries.
- Della Barnes claimed to be single during the antenatal period yet, he was clearly present on occasions as her partner.
- During the first few weeks of Leah's life there had been episodes of disengagement with the Health Visiting service
- The Health Visiting service was aware that Mark and Della had had previous problems in their relationship when Keifer was born, resulting in a court case to determine contact rights.
- Della Barnes had told Health Visitors around the time of Keifer's birth that Mark Dennis had made threats to her family in the past and that he could get very aggressive.

5.1.17 The GP IMR Report Author commented, *'It is clear that when the notes are compiled into a chronology for the father there are significant pieces of information that would indicate risk factors for Leah and reflect a*

very poor experience that Leah's father must have had when growing up.' It is noted in the NHFT IMR Report that research shows that neglectful and domestically abusive parenting can have long-term impact on that child's future ability to parent (Howe et al, 1999). As Mark Dennis had, as a child, experienced neglect and non-accidental injury there are associated risk factors that this model of parenting could continue into Mark's own parenting style and this could have been considered as a risk had it been known by midwifery services. Had it been accessed, the accumulation of information as described above should have triggered a Common Assessment Framework (CAF)¹ which might have led to different lines of enquiry to establish whether Leah needed extra services from universal providers or even an Initial or Core Assessment by Children's Social Care.

5.1.18 It has therefore been a recurring theme in Northamptonshire that a father's notes are not accessed by Community or Health Visitor either because of data protection, resourcing implications, or a culture of treating the mother as the only client, yet everyone agrees that in some situations this may put children at risk and this is borne out by research (Brandon, 2009). The LSCB should be concerned that a system for safeguarding children is either hampered either by an administrative resource issue or a cultural issue which ignores the research about the danger of ignoring fathers within families. The LSCB should actively look at ways in which, through a mature multi agency discussion, current midwifery and health visiting practice can be developed or improved to ensure that such practice adopts very much a 'think family' approach, that it encourages engagement with fathers, and where any observations or information suggest that a father may need extra help with parenting or indeed might be a risk as a parent, his full notes are always accessed.

RECOMMENDATION 3

5.1.19 The issue of failing to understand the profile of Leah's father was also a factor when health visitors took over the primary care after 10 days had elapsed. It is clear that the Health Visiting Team engaged with Leah

¹ The CAF was established by the former Department for Children, Schools and Families. It is described on their Every Child Matters website as "a standardised approach to conducting assessments of children's additional needs and deciding how these should be met...The CAF promotes more effective, earlier identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development"

Barnes also knew little about Mark Dennis' background or his ability to parent a child. It is noted in the NHFT IMR Report that, '*No information was provided to, or actively sought by the HV team regarding the level of support that Mark received following his injuries, nor the impact that these injuries may have had on his abilities to parent both Keifer and Leah.*' When the Overview Report Author met him, Mark Dennis was clearly in pain. He was limping, and only had one eye. It is reasonable to suggest that upon meeting him, a midwife or health visitor should have enquired as to whether he had any extra needs in terms of parenting. The evidence provided to this review however indicates the health visitors never met him or even tried to meet him.

5.1.20 The NHFT IMR Author makes a convincing argument that more should have been done by health visitors to gather information about Leah's father, as her report goes on to say, '*A more thorough and detailed assessment process, involving questions being asked about Mark and his role within the family unit may have uncovered facts that had been previously unknown to the Health Visiting Service. The changes that had occurred to Mark's health and wellbeing since the birth of Keifer may have played a significant role in the care that he could provide to both Leah and Keifer, and impacted on the subsequent injuries that Leah sustained. This assessment process should begin during pregnancy and should entail effective working and information sharing between the GP, community midwife and health visitor. Assessment tools need to include questions about historic social and mental health interventions for both parents, and any other adults with whom the child may live.*' This case reveals that formal communication between GPs and Midwives, and vice versa, at the very beginning of pregnancy is not a routine aspect of GP care in Northamptonshire and if Recommendation 3 is accepted, the LSCB should explore whether this culture can also be challenged.

5.1.21 It was felt by the health agency IMR Reviewers that the lack of any formal handover between midwives and health visitors may have contributed to the failure to gather relevant information about him. According to the NHFT IMR Report, the HV service specification recommends a '*formal transfer of responsibility through a documented handover process between midwifery and the Health Visiting teams as per the HCP 0-5 years*'. This did not happen in respect of Leah and her mother. It is possible that had a formal handover taken place, the gap in information about Mark Dennis may have been discussed, particularly as the Health Visiting service were well aware who he was, and knew that he

was a violent man. Analysis in the IMR Reports dealing with midwifery and health visiting respectively did not reveal a reason for a lack of formal handover but there were no HV vacancies at Leah's GP surgery at the time of the incident so it is unlikely to be because of staff shortages or excessive work pressure. Rather it seems that this is the norm in Northamptonshire, and the analysis indicates that communication between health visitors and the midwifery service normally happens on an ad hoc basis, mainly catching up on a Monday at the GP surgery. Any concerns or issues in respect of the antenatal or postnatal periods of care are discussed at these 'catch-ups', however, no formal record of discussions is made.

5.1.22 Apart from the lack of a formal handover of the case, it was confirmed by the Health Overview Report Author that currently within Northamptonshire there is no system of passing on written 'handover notes'. This is because although within the Health Visitors Service Specification it acknowledges this is meant to happen, within the Maternity Service Specification it does not. This is an unacceptable approach and in order to properly safeguard vulnerable children it is crucial that a formal handover process is developed and adhered to. A new process is currently being undertaken with Northamptonshire to ensure written handover notes are universal but this should be monitored by the LSCB to ensure it is working seamlessly. **RECOMMENDATION 4**

5.2 Sharing or Accessing Information Held by the Army

Linked to the following ToR themes:

The way in which agencies work together to identify concerns, share information and support armed service personnel living in localities and accessing a range of services across local authorities.

What efforts were made by agencies to access information held by the armed services in relation to Leah's father's physical and mental health?

Were appropriate actions taken by agencies in response to any indicators that Leah might be at risk of significant harm or vulnerable to becoming a child in need?

Are there particular lessons arising from the interface between agencies?

With hindsight what, if anything, could have been done differently and what impact, if any, such action may or may not have had on the outcomes for Leah?

5.2.1 Mark Dennis joined the Army in January 2005 and he served for eight years, during which time he was posted to Afghanistan. He was seriously wounded in action on 3rd November 2009, having received several gunshot wounds, and he was evacuated to the UK where he underwent a detailed programme of care and rehabilitation which included psychiatric assessment and treatment. He suffered serious injuries some of which left him with permanent physical disabilities and he was subsequently medically discharged on 25 April 2013m having been formally diagnosed by an Army doctor with Post Traumatic Stress Disorder.

5.2.2 Evidence provided for the current review reveals that medical professionals either working for, or working with, the Army, had specific information which should have led them to conclude that if caring for children Mark Dennis might present a danger to them in terms of their physical safety. This information was not shared outside Army medical services and the analysis in this Overview Report needs to examine whether it would have been appropriate to share any such information with civilian authorities.

5.2.3 It is important first to explore whether, in a safeguarding sense, the Army has a different status than any other 'employer' such as Tesco. It can be argued that the Army does have a special status in the sense firstly that it is a publicly funded organisation, and secondly that it provides a holistic welfare approach to service families thereby rendering it unnecessary for many Army families to seek universal services outside the institution of the Army. The Royal Military Police (RMP) Armed Forces IMR Reviewer explained that the Armed Forces '*should in this context be likened to a local authority. It comprises the majority if not all of the medical, welfare and social services which are provided by any civilian local authority, as well as some expert medical and welfare support*'.

5.2.4 The Army accepts responsibility for the healthcare of service personnel and their families, but a distinction is drawn between those

family and children to married soldiers and/or serving with them overseas and unmarried partners/children who, whilst residing in the UK, fall under civil jurisdiction. That being so, it seems crucial that the Army also accepts responsibility for promoting, wherever possible, the welfare and safeguarding of the children of serving soldiers when that soldier is actively participating in their upbringing. Indeed, it is well established that this is the case and the Armed Forces have specialist social workers as well as trained child protection law enforcement personnel within the Royal Military Police. It is also useful to be reminded of the Armed Forces contribution to the statutory Government Guidance Working Together to Safeguard Children (2010).

Young people under 18 may be in the armed forces as recruits or trainees, or may be dependants of a service family. The armed forces are fully committed to co-operating with statutory and other agencies in supporting families in this situation, and have procedures to help safeguard and promote the welfare of children.

5.2.5 In many areas with a high military population the Armed Forces are members of the Local Safeguarding Children Boards and it seems clear therefore that unlike a regular civilian employer the Army is an employer which accepts a responsibility to share relevant information which might safeguard a child. Military Personnel have access to child protection trained social workers from the Army Welfare Service (AWS). Army Welfare Service social work teams take part in local forums, such as Safeguarding Children Boards, to bring the perspective of military personnel to these complex issues. Leah and Keifer Barnes were the children of a serving soldier who was an active parental figure in their lives and therefore if a medical professional either working for, or working on behalf of, the Army knowingly held any information which may have had a bearing on their safety, this should have been shared with either the Army Welfare Service (AWS social work), or the civilian safeguarding agencies in the same way that one would expect an NHS paediatrician or GP to share such information with their local Children's Social Care.

5.2.6 As will be further discussed in this section of the report, Mark Dennis was receiving treatment from Psychiatrists and Psychiatric Nurses. It is generally accepted that in the civilian environment, those professionals providing a mental health service to adults also have a responsibility to promote and safeguard the welfare of children. Working

Together to Safeguard Children (2010) is quite clear on this and contains the following statutory guidance.

Adult mental health services – including those providing general adult and community, forensic, psychotherapy, alcohol and substance misuse and learning disability services – have a responsibility in safeguarding children when they become aware of, or identify, a child suffering or likely to suffer significant harm. Adult mental health staff need to be especially aware of the risk of neglect, emotional abuse and domestic abuse to children. Staff should be able to consider the needs of any child in the family of their patient or client and to refer to other services or support for the family as necessary and appropriate

It is similarly important that adult mental health liaise with other health providers, such as health visitors and general practitioners. This may require sharing information to safeguard and promote the welfare of children or to protect a child from significant harm.

5.2.7 Bearing in mind the earlier discussion on the general safeguarding responsibilities of the Armed Forces, it can be argued that an adult mental health worker providing a service to a serving soldier on behalf of the Army, has exactly the same responsibility to promote the welfare of children, and to share relevant information, as their counterpart working in a civilian environment.

5.2.8 It is also the case that civilian local authorities, health services and police forces should where necessary seek information from the Army if it might help a risk assessment into the safety of a child living within their area. In the current review, there is clear evidence that not only did the Army fail to share important information, but also that civilian agencies failed to seek from, or share information with, the Army which may have had a bearing on the action all agencies took when providing a service to Leah and her family. For example, in the months before Leah's death, Northamptonshire Police recorded three incidents of domestic violence, or 'threat danger' involving Mark Dennis. Despite being aware that he was a serving soldier, the police did not notify either the Service Police Crime Bureau (SPCB), which is the Single Point Of Contact (SPOC) for all Home Office Police Forces with whom access to data and information is shared, or the local RMP unit (in this case Colchester). Sharing this information would have identified to the Army his propensity for violence and

highlighted his potential as a domestic abuser to the Army chain of command. As will be discussed shortly, such information in his Army records might have led doctors to take a different view about sharing information concerning child safeguarding.

5.2.9 Military personnel and their families are members of society and they do not live in an impenetrable bubble whereby information cannot be shared within and without the confines of that organisation. Any Serious Case Review should look closely at an apparent failure to share relevant information between agencies, and where such failure is identified there is the likelihood that this would attract criticism in any analysis. It would be inconsistent for Army medical services to be considered immune to the possibility of such potential criticism.

5.2.10 During the time Mark Dennis was in the Army, he was registered as a single soldier and lived in barracks in single soldiers' accommodation. He had no dependent children registered and his nominated Next of Kin were his parents. Upon joining the Army, the recruit is required to specify on a form if they have a 'significant other' but they would not be routinely asked if they had children. The Casualty Visiting Officer was aware from the family visiting at Selly Oak that Mark Dennis had a child (Keifer) and he arranged for Della and Keifer to visit him in hospital, but did not record that fact in his army records or amend his 'status' as not being a single man. It is reasonable to conclude therefore that until his intensive treatment, the Army would have had no reason to consider the welfare of Leah or Keifer.

5.2.11 There came a point however when it should have been clear to senior medical personnel that he was in fact a carer for one or more very young children and that he may be a risk to them in terms of physical safety. This point came on 2nd August 2010, when AFLCGP1, a locum civilian doctor or, General Medical Practitioner, working on behalf of the Regimental Medical Officer, saw Mark Dennis for a consultation. During the consultation, Mark Dennis admitted to low mood some of the time but said that it was nothing he could not deal with. With regards to his anger issues, he stated that he tended to be angry before he was injured but that now he would fly off the handle at the slightest thing. He gave an example that if he broke a cup his day would be ruined. He told AFLCGP1 he had a 14 month old child (Keifer) who he *'did not like to be left alone with because he feared what he would do if the child would not stop crying'*. He also told AFLCGP1 that he had split from his girlfriend and they

had joint custody of Keifer. This information was recorded in the electronic medical records held by the Army but no referral was made to any other internal or external agency. It is confirmed by the Health Overview Report Author that had this conversation taken place in a civilian GP surgery there would be an expectation on the GP to share that information with partner agencies, to have a frank discussion to discuss with the patient the need to do so, and to assess the risk to the child.

5.2.12 There can be no question therefore that this clear indication that Mark Dennis was the carer of a 14 month old child, and that he himself felt he was a risk to the child's safety, was relevant information that should have immediately triggered an enquiry into the welfare of that child and any siblings. The doctor in question was asked to contribute any learning to the current review and when asked whether she should have referred the case to the Army Welfare Service, the patient's civilian GP or the Royal Military Police she commented, *'I should have referred him to AWS, but I didn't. I was not aware of his civilian GP and the RMP's a debatable one I think.'*

5.2.13 It is often the case that professionals have to piece together small bits of information to try and assess whether someone is a risk to a child but in this case, no 'detective work' was required as the carer explicitly declared that he was a risk. This failure to share the information with either a civilian safeguarding agency, the AWS Social Work Service or the Royal Military Police, was a crucial missed opportunity to ensure that when Leah was born 7 months later, safeguarding agencies were aware of the considerable risk that Mark Dennis posed to her.

5.2.14 Mark Dennis subsequently received treatment at the Department of Community Mental Health (DCMH) Woolwich, London, between 26th August 2010 and 17th November 2010. He was seen by Psychiatrist 1 a Consultant Psychiatrist contracted to the Army, and Warrant Officer Class 1 (WO1), a Community Psychiatric Nurse, who treated him for anger management. The DCMH centres are part of the military healthcare spectrum and as such, in a safeguarding children context, the staff working there are bound by the same information sharing requirements as the medical staff in purely civilian institutions.

5.2.15 On 26 August 2010, Psychiatrist 1 held his initial consultation with Mark Dennis. Psychiatrist 1 recorded that Mark Dennis had, *'anger issues, has always had a quick temper, but now gets angry at the slightest issue*

and will overreact, as an example he decided not to see his 14/12 son alone as he was losing temper with him. His family history was recorded as, 'son lives in Northampton with his mother, [Mark] also has house in Northampton and sees son as often as he can'.

5.2.16 In offering a comparison with what should have happened in 'civilian life' if an adult mental health worker had received similar information from a patient, the Health Overview Report Author explained, *'These are risk issues and in civilian life they should feed back to the patient's GP. There is an explicit expectation that you identify vulnerable children of people presenting for services and that you risk assess.'*

5.2.17 It is clear therefore that in August 2010, Psychiatrist 1 knew that Mark Dennis was a primary carer for his 14 month old son Keifer and that he feared being with his son alone because he was losing his temper with him. This is almost the same information received by AFLCGP1 3 weeks before, yet again no follow up enquiries were conducted to find out whether there were any safeguarding concerns for Keifer and no information was shared either internally to AWS or the RMP, or externally to Children's Social Care or other health agencies in Northampton where it was now known the child lived. This was another critical failure in information sharing. It not only left Keifer at risk of significant harm but was another missed opportunity for Leah Barnes to be properly protected when she was born the following year.

5.2.18 Psychiatrist 1 was also invited to contribute to the learning within the serious case review and when interviewed, he explained *"I had two observations from him; I am getting angry with my child; I would never harm him; and that was what I had to base the risk assessment on and in my mind at the time they were sort of balancing each other out. With hindsight, and I have spent time thinking what I would do now, I would if I felt there was a serious... Yes I should have contacted local social services the multi agency safeguarding hub that they have in Northamptonshire, or the NSPCC would have proved very helpful or Army welfare services."*

5.2.19 After one further session with Psychiatrist 1, Mark Dennis' mental health care was transferred to a Community Psychiatric Nurse, WO1. At a meeting between them on 3rd November 2010, Mark Dennis revealed that he had perpetrated domestic violence against his girlfriend. It was recorded in the notes that he (Mark Dennis) *'has had a couple of anger*

related situations towards his girlfriend, snapped at her, grabbed her, threatened to hit her'. Such information should also have been shared with relevant external civilian agencies, and the CPN should have further enquired as to whether there were children in the family and discussed with Mark Dennis, the need to share information with for example his child's Health Visitor. It is also important to note that this was part of the suite of information within Army records potentially available to civilian agencies when Leah was born 5 months later.

5.2.20 Military families are offered healthcare from a mixture of military doctors and civilian doctors working for the Army medical services. All medical staff working within the Army environment are expected to comply with certain child protection and safeguarding guidance documents. These documents include JSP 834 (Issue 1.0, 28 July 2009) Section 2, para 0114, which highlights the duty of all organisations to ensure there is effective inter agency working to safeguard and promote the welfare of children, through applying the 'duty to co-operate' and that they have effective systems in place for sharing information; Section 7 – Training, para 0159, lists six competencies that everyone working with children, young people and families should be able to demonstrate and these include effective communication, safeguarding and promoting the welfare of children, multi agency working and information sharing; Annex D, Section 3, Para 0196 addresses confidentiality and the ability to disclose relevant information in order to safeguard a child. The policies are underpinned by reference to the intercollegiate document, Safeguarding Children and Young People; roles and competence for health care staff 2006, revised Sep 2010. *NOTE: It is accepted that an Overview Report is not usually enhanced by listing numerous guidance documents which should have been followed by professionals. Because of the important role played by Armed Forces personnel this case is rather unusual and the documents are listed here simply to illustrate that medical staff working for the Army have the same duty (and crucially they have the same protection from potential criticism) as their civilian counterparts when sharing confidential information in a safeguarding children context.*

5.2.21 Key medical personnel working within the military environment also receive specific child protection (CP) training and relevant to this case is the fact that Psychiatrist 1 received CP Training on the 16/10/2009 and 21/02/2011, and AFLCGP1 received CP Training on 17/03/2010. They are both experienced medical practitioners and it

seems inconceivable that they both independently failed to share such clear child protection concerns particularly as, with the benefit of hindsight, they both agree they should have acted differently.

5.2.22 To try and establish why these doctors failed to share their concerns, AFLCGP1 was asked whether she felt her safeguarding training was adequate. Her response was, *"No, I think the failure is that they don't specifically teach people in my position about the fact that you may be dealing with children who are not necessarily your patients and may be at the other end of the country and how that probably differs from almost every NHS GP. I felt that has not been addressed to quite the level it needs to be. I went to level three training in Kensington and it is all very specific about the whole family and doesn't really address people in my situation, who are dealing with a soldier on their own and, as a whole rarely, have contact with the rest of the family."*

5.2.23 In his report for this SCR, the RMP IMR Reviewer makes the following analysis. *'It is recognised that there should have been greater coordination between agencies within the Armed Forces themselves and then with their civilian counterparts. There were missed opportunities to raise concerns regarding Keifer Barnes, which may have subsequently helped Leah prior to and after her birth. Once Mark Dennis disclosed to the GP and Consultant Psychiatrist his own concerns regarding anger towards his son, safeguarding issues were not correctly identified and raised, which are not consistent with either MoD policy or their professional standards.'*

5.2.24 It is my view, and the view of the SCR Panel, that had the collective information from both army doctors been shared with Children's Social Care in the area where Keifer lived, it should have triggered at least an Initial Assessment by the Local Authority and probably a Core Assessment. If the subsequent enquiries had revealed what was known by the GP about Mark Dennis' troubled history the Assessment should have concluded that Keifer was a child at risk of significant harm. In turn, when Leah was born a full safeguarding assessment might then have then been conducted.

5.2.25 As stated at the beginning of this Overview Report, the analysis is underpinned by the firm belief that Leah Barnes was killed by Mark Dennis. The failure by two doctors working for the Army to act upon Mark Dennis' own stated concerns that he was a risk to his 14 month old child,

contributed in no small way to a dangerous gap in the information available to build a proper risk assessment for Leah. It is reasonable to conclude therefore that Leah's death might have been prevented had the proper sharing of such important and relevant information held by the Army about Mark Dennis taken place and then been appropriately followed up by the civilian statutory agencies.

5.2.26 There are around two hundred thousand British armed forces personnel, and consequently there are likely to be many thousands of children living in various communities throughout the UK whose primary carers include a member of the armed forces. At the moment, it seems that relevant information is not shared as seamlessly as would be the case with a purely civilian family. To ensure adequate safeguarding of these children there is a need to examine, and if necessary improve, the information sharing arrangements between military medical and social work teams and their civilian counterparts. The LSCB should urge the Department for Education and Ministry of Defence to consider how this can be achieved. **RECOMMENDATION 5**

5.2.27 Training for professionals within both the military and civilian sector needs to equip them with the confidence and knowledge to seek appropriate information when it is felt necessary to assess safeguarding concerns. Although it is not within the remit of this serious case review to make recommendations to specific agencies, there seems to be a serious systemic failure to share important information of a safeguarding nature. It is strongly suggested that the Armed Forces consider that when they provide safeguarding training for their staff within medical services, the training deals with the particular nuances of being a military doctor.

5.3 The Six Week Check

Linked to the following ToR themes:

Did the professionals working with Leah and her family have the required knowledge, skills and experience regarding the identification of and required response to possible child abuse and domestic violence? Were there any gaps in practice that may have impacted upon the outcomes for Leah?

With hindsight what, if anything, could have been done differently and what impact, if any, such action may or may not have had on the outcomes for Leah?

5.3.1 Hindsight bias is not helpful when analysing practice but asking whether it was *reasonable* for practitioners not to have recognised that which we now know, is a necessary part of the analysis of practice in a Serious Case Review.

5.3.2 A standard procedure within the universal health care system is for a health visitor to carry out a development check on a baby 6 weeks after the birth. In addition, a GP should also carry out an extensive mandatory 6-8 week check. In Leah's case, the Health Visitor's 6 week check was carried out within the correct timescale on 3rd May 2011, but was delegated to a Community Nurse (CN). The SCR Panel's advice is that if there are no identified concerns about a child this is not an unusual situation, bearing in mind the primary care team includes a skill mix, and currently the way of working is that the CN would often do the 6 week check on behalf of a Health Visitor.

5.3.3 The formal GP's 6 - 8 week check was never carried out because Leah was admitted to A&E with serious injuries at around the time it was due. By coincidence however, on 4th May 2011 Leah's GP did examine her because she was brought to the surgery for an emergency appointment with a reported throat infection. Leah was therefore seen by two health professionals within the 5 days before she was taken to A&E with serious injuries.

5.3.4 As described earlier in this report, post mortem and radiological examination now reveal that Leah's injuries included a fracture to her skull, bleed on her brain, bleed on her spine, multiple retinal haemorrhages, multiple rib fractures, fracture to her right arm, fractures to her leg, and fractures to her spine. In a report prepared by a Consultant Paediatric Radiologist and made available to this review, he concluded that among the other injuries there were '*old and recent rib fractures, caused by likely squeezing to the chest on two separate occasions*'. The Paediatric Radiologist considered that six rib fractures looked older than the others and occurred between 3 and 6 weeks before the 9th May 2011 when the image was taken. He also concluded that the fracture to Leah's right arm was caused between 4 days and 18 days before the 8th May 2011. The Paediatric Radiologist indicates that a

realistic assessment is that the injuries were caused over a period of time during five separate attacks (although as stated earlier, a social care report indicated at least four separate attacks). Whilst it cannot be established for certain how many times Leah had been assaulted or how many injuries were present at the time of the 6 week check, the Health Overview Report Author comments that at the time Leah was examined by the Community Nurse and her GP, *'it seems likely that Leah was experiencing pain in relation to previously inflicted fractures.'*

5.3.5 It is recognised that some injuries, including fractures, to new born babies may remain undetected. For example, in one study (Uhing, 2005) it was estimated that in the case of a relatively common birthing injury, a fractured clavicle, perhaps 40% remained undetected whilst the child was in hospital. However Paul and Williamson (2010) also suggest that *'Community practitioners can pick up undiagnosed clavicle fractures in neonates'* and in particular, that it is possible to identify such fractures for example, by observing a lump over the collar bone, feeling for a palpable spongy mass, localised tenderness or lack of upper limb mobility. If a single fractured clavicle is, if properly looked for, detectable in a baby, it will seem astonishing to many lay people that a baby with such severe and extensive fractures as Leah had suffered would not immediately be identified as a victim of maltreatment upon being examined by a medical professional. It is therefore necessary in this case to apply what we now know in respect of the injuries already sustained by Leah at the time of her 6 week check by the Community Nurse and the examination by the GP for a throat infection, alongside a discussion about whether the check and examination were carried out to the required standard and whether it is reasonable for a thoroughly completed check by a trained health professional not to have detected such injuries.

5.3.6 As mentioned earlier, this Serious Case Review has benefitted from information discovered during the police murder investigation. The police interviewed members of Leah's family and the police investigation has revealed that family members did have some concerns about Leah's well being. They described Leah as being a 'pale unresponsive baby', that the 'child's head looked misshaped' and that they had 'seen bruising on Leah's forehead'. They had advised Della Barnes to seek medical advice but they had not made any reports of these concerns to the Police (or anyone else) prior to Leah's death. It is noted that these observations were made to the police in witness statements by people who may have had a vested interest in the outcome of any criminal investigation and

therefore must be weighted accordingly. However, if it is the case that Leah had such an obviously abnormal physical appearance that it was noted by family members, this information must be of relevance when analysing the 6 week medical check up.

5.3.7 The Health Visiting Service Specification commissions only a primary visit at 10 days and a Health Visitor contact at six weeks for the routine six week development check. The primary check on Leah was carried out by a Health Visitor on 6th April 2011 when Leah was 17 days old, and according to the NHFT IMR Report, it involved *'a detailed 'top to toe' examination of Leah which included actual hands on physical contact, along with weighing and measuring Leah whilst she was naked. The top to toe examination involved checking her skin, fontanel's, her eyes and ears, inside her mouth and palette, around her neck, her nipples, genitalia, spine down to her ankles and her toes'*. As discussed earlier Leah's 6 week assessment was carried out by a Community Nurse and in contrast to the full examination outlined above she used what was described in the NHFT IMR Report as a 'hands off approach', which basically means that Della Barnes handled and undressed the child and at no time did the CN actually touch Leah to see if her limbs were moving equally, or to check warmth, or to see how she responded to touch.

5.3.8 A Community Nurse is a trained paediatric nurse with adequate training and competences for dealing with routine cases, which Leah was at that time considered to be. Within the primary care team skill mix a Health Visitor has much more experience at dealing with child development and deals routinely with parents on Child Protection Plans. A Community Nurse will be more familiar with simple health and development although they will have undertaken safeguarding training. In this particular case the CN had trained as a paediatric nurse, qualifying in 2001. Prior to undertaking nurse training, she had qualified as a nursery nurse. She gained experience as a trained nurse on a paediatric ward and subsequently worked on a special care baby unit (SCBU) for 2 years. The Health Visitor for Leah felt confident in the practice of the community nurse as they had worked together in the past on the same SCBU. However, there is no evidence to demonstrate that the community nurse had received specific training, or had been assessed regarding her competence, to carry out a 6 week development review. Recommendations about modernising career and educational pathways for health professionals in general and nursing in particular include a foundation period of preceptorship after qualification (cited in Robinson &

Griffiths, 2009). Preceptorship is a process which was introduced to nursing in order to ease the newly qualified nurse into the role. The concept of preceptorship can be applied to any new role undertaken by a nurse to ensure they are eased into the role and that their practice is safe but the CN who examined Leah had not started her preceptorship at the time she carried out the 6 week check – indeed she had been in post for 2 years before she commenced her preceptorship which seem to defeat the object of this scheme. No information was provided for this review as to why this process had not started earlier, neither is it clear whether this is normal within NHFT.

5.3.9 Although no-one had previously raised any concerns about Leah, during the first few weeks of Leah's life there had been episodes of disengagement with the Health Visiting service, and Leah's Primary Birth Visit was carried out later than recommended. Specifically, the fact that her mother had failed to keep four Health Visiting appointments and was sometimes un-contactable should have been identified as concerning factors. The view of medical delegates on the SCR Panel however, is that even had these factors been considered, there would still have been no particular requirement for a Health Visitor rather than a Community Nurse to have carried out the 6 week check.

5.3.10 It is the view of the NHFT IMR Reviewer that although a 'hands off' approach was used, the check by the Community Nurse '*...was completed to currently expected standards.*' The NHFT Reviewer also notes, '*Most of the physical handling of Leah was done by Della. This included fully undressing her and placing her in the scales with the community nurse observing throughout. Leah did not show any apparent discomfort or distress.*' It seems therefore that none of the techniques described in paragraph 5.3.5 above, which might have detected the presence of fractures, were employed during this examination.

5.3.11 A number of vulnerability factors were identified at the 6 week check, such as Della Barnes feeling low and Mark Dennis having serious injuries. Leah reportedly looked well and was feeding well, although it was also noted that her weight had dropped from the 25th centile to the 9th centile. Although this is abnormal, the advice to the SCR Panel was that this would not necessarily have triggered further investigation beyond the plan which was put in place to weigh her again in 4 weeks. A plan for monitoring the family vulnerabilities was not considered, and even though the Family Assessment Tool noted that the primary care team wanted to

offer slightly higher levels of support they didn't make a firm plan. It is noteworthy that Health Visitor home visits took place on weekdays only and therefore with Mark Dennis being a weekend only visitor to the house it is unlikely that he would have been seen on a routine visit. It was felt by the SCR Panel that further enquiries should have been made about the level of parenting Mark Dennis was involved in and perhaps for the Health Visitor to make a specific arrangement to meet him.

5.3.12 Apart from these relatively minor observations, the analysis provided by health IMR Reviewers, as well as the view of the health representatives on the SCR Panel, is that the Community Nurse 6 week check visit was carried out in line with the service specification.

5.3.13 The family GP, (GP1) delivered care to Della, Keifer and Leah Barnes from a small two doctor practice that provides care to 3500 patients. Although there are two partners in the practice, one of the doctors is part time. The GP had attended the appropriate child protection training that was delivered in 2009, 2010 and 2011. Doctors at the practice have seldom attended the safeguarding forums where discussion of serious case reviews takes place.

5.3.14 The only occasion GP1 saw Leah was on 4th May 2011, 4 days before Leah was taken to A&E with serious head injuries. Leah was 6 weeks and 2 days old and was taken to surgery by her mother because of for a suspected throat infection. It was noted by the GP that Leah was *"not feeding well. Loose stools. Bit watery. temp 37.2. throat slightly congested. Chest clear. Abd=nad. No neck stiffness"*. A prescription for antibiotics was given. Although Leah had been presented at 6 weeks and 2 days the GP practice did not take the opportunity to undertake the 6-8 week check at the time. This would not be considered unusual practice as the length of appointment time would not have been sufficient to undertake a comprehensive assessment. There is no evidence that any safeguarding concerns had been shared with the GP.

5.3.15 Due to the length of time that had elapsed between this examination and the enquiry by the GP IMR Reviewer, GP1 had no independent recollection of the extent of his check on Leah. The assessment of a 6 week old newborn when presenting with an upper respiratory tract infection (URTI) would normally include an examination of the chest by completely stripping the child down to its nappy to ascertain whether there was any signs of respiratory distress. Respiratory

distress is normally seen as a physical sign by the skin around the ribs being sucked inwards. Doctors also listen to lungs with their stethoscope for extra noises in the lungs. The visual inspection of the chest is paramount to making a full assessment of how the child presents.

5.3.16 The term 'abd=nad' in the GP notes indicates that the doctor examined Leah's abdomen and nothing abnormal was found. This is despite the undoubted presence at that time of at least 6 recent rib fractures. The GP IMR Reviewer reports that when examining an abdomen, doctors may palpate the abdomen through clothes but a full examination of a baby's abdomen would include inspection of the skin. A doctor is assessing for pain, tenderness or masses. Visual inspection is made to exclude herniae of the umbilicus and in the groin (inguinal or femoral). To examine the abdomen adequately you would need to at least unfasten the babies clothing, lift the garment to expose the abdomen, and normally lift vest to expose the chest.

5.3.17 As discussed at paragraph 5.3.4 above, it is quite clear from the medical reports now in existence that the Community Nurse and the GP were unable to identify fractures and injuries when examining Leah. The view of the Health Overview Report Author is that this is not necessarily unusual because she explains '*a 6 week CN check is for feeding, general wellbeing etc. It may not pick up serious injuries. Routine physical contact could easily miss rib fractures. There is a huge problem with a belief and assumption that health professionals can always pick up injuries in a young child during these checks.*'

5.3.18 Since the Community Nurse apparently did all that was required during the 6 week check and the GP apparently did an abdominal examination and they both missed the fractures, one possible conclusion is that this is just what society will have to accept. However, some SCR Panel members with a non-medical background, as well as the Overview Report Author, feel that this seems too complacent and although the evidence provided to the current review is that the checks were 'in line with the service specification', the evidence provided from the police murder investigation would seem to suggest that these medical professionals were unable to identify fractures which we now know were definitely present as well as concerning physical signs that family members claim to have noticed. This leads to another possible conclusion that the 'service specification' needs to be reviewed at a national level to ascertain whether the guidelines given to health professionals when

carrying out these checks could be improved upon. It is obviously not proportionate or feasible for every child to undergo X Rays at the 6 week stage, but through the Department of Health the LSCB should invite the relevant professional bodies, such as the Royal College of General Practitioners, to examine the case which triggered this serious case review and consider whether there are further reasonable tests or steps which could be taken at the 6 week stage to determine whether any baby is suffering from gross injuries of the nature described in this report. **RECOMMENDATION 6**

5.4 Triggering a Serious Case Review

Linked to the following ToR theme:

It is a matter of concern that this case was not referred to Serious Case Review Committee following the serious and life threatening injuries sustained by Leah on 8 May 2011.

5.4.1 Although there was no mandatory requirement to do so, it is unacceptable that the LSCB did not commission a Serious Case Review shortly after Leah was admitted to A&E on 8th May 2011. The Government guidance *Working Together to Safeguard Children* (2010) requires that LSCBs should consider whether to conduct a SCR whenever a child has been seriously harmed and sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect and there were concerns about how the agencies worked together. There is little doubt that Leah was such a child and the failure to trigger this Review at that time has reduced the opportunities for learning because any reliance on the physical memories of the practitioners concerned has been compromised by the passage of time.

5.4.2 It is evident that the reason a Serious Case Review was not considered by the LSCB Chair is because no-one with knowledge of the circumstances made a formal request or notification to the relevant LSCB Sub Committee, although as will shortly be discussed, the Chair of the SCR Sub Committee is believed to have been notified about the serious injury to Leah, but in her role as a senior social worker, not the Committee chair.

5.4.3 The LSCBN Child Protection Procedures (2012) make it clear that it is the responsibility of the LSCB Chair to commission a Serious Case Review. It is also clearly stated that, *'any professional or agency may refer a case to the LSCB if they believe that there are important lessons for intra- and/or inter-agency working to be learned from the case.'*

5.4.4 However, even though the wording in the LSCBN Child Protection Procedures is well intentioned, there is evidence that professionals are not sufficiently aware of their responsibility under this part of the procedures and that a lack of training and confidence led to a failure to refer to the LSCB.

5.4.5 For example, information from NGH revealed that in relation to such a referral not being made, this reflects a time when there was no Named Nurse in post at NGH and the Safeguarding Team as a result lacked expertise, and both SG1 and the Modern Matron who were sharing the responsibility were not aware of the process for referral.

5.4.6 The SCR Panel member for the Police indicated that it was unlikely her colleagues would realise that they were able to instigate consideration for a serious case review and the same probably applies to NHFT staff and Leah's GP.

5.4.7 Although laudable to state that 'any professional' can make a referral to the LSCB for a serious case review, it is perhaps unrealistic to expect a junior member of staff in any agency to do so. Perhaps the LSCBN Child Protection Procedures should be amended slightly to include a specific responsibility on the LSCB agency delegates themselves to support any member of staff from their agency who feels a case may meet the SCR threshold. It should be the case that it is the responsibility of the LSCB delegate from any of the LSCB partner agencies to trigger consideration of a Serious Case Review if they feel the criteria are made out. The LSCBN Procedures should be amended to make this clear.

RECOMMENDATION 7

5.4.8 Although a lack of knowledge about the referral system was undoubtedly a factor in this SCR not being instigated earlier, it also emerged during the SCR Panel meetings that at the time of Leah's serious injuries, correspondence from the police was faxed to a senior professional within Children's Social Care notifying her of the serious injury. This particular person happened to have a dual role as the

Safeguarding Manager for the Northampton Conference and Review Service (NCRS) and she was also the LSCB SCR Committee Chair. Information provided to the current review suggests that technically the police referral was made to the individual in her role as Safeguarding Manager and in the event the referral was 'filed away' and not put before the SCR Committee for consideration for a Serious Case Review. It has been suggested that in this case the two roles may have been blurred and that the individual considered that in her position as SCR Committee Chair she had responsibility to screen in or out potential SCR referrals thereby acting independently of the SCR Committee.

5.4.9 The particular individual concerned no longer works within Northampton and has not been interviewed as part of this SCR so this information should be weighted accordingly and no criticism of the individual is intended or implied. However, it is important that anyone holding the role of SCR Sub Committee Chair acts collaboratively with their committee and ensures that all referrals from agencies or individuals are considered by the whole committee.

6. Findings from previous SCR's which might assist in the learning

6.0.1 The Serious Case Review concerning Child I was conducted in Northamptonshire and covered a period between February and March 2012. Although Leah suffered her significant injuries nearly a year earlier, the Child I review revealed the same cultural issues concerning 'invisible fathers' and is therefore of relevance to this case. A key issue identified by the Child I review was that there was a considerable body of information in health and education records which indicated that the child's parents had both suffered a traumatic childhood and that had it been accessed the information held in agency files about the parents own troubled background should have triggered a more intensive assessment of their parenting capacity and possibly enquiries under the Common Assessment Framework.

6.0.2 As is the case with the current review, it was revealed during the Child I SCR that paternal medical records were not accessed by community midwives as it was considered that community midwives only have the professional/client relationship with the expectant mother and the unborn child. It was also perceived to be a breach of the Data

Protection Act to access a father's medical records. The reason for midwives not accessing relevant information about the child's parents held by the GP was that without prior safeguarding concerns this would not be routinely done.

6.0.3 The Child I SCR also revealed that the primary health professional working directly with the family was a Student Health Visitor who had been assessed by her HV Mentor as competent to undertake home visits alone. Whilst no evidence was found to suggest that the work carried out by this Student HV was anything other than satisfactory, there were concerns about the process by which she was allocated this family and also a lack of adequate supervision. This situation has certain similarities with the current case whereby the Community Nurse had not been specially trained to carry out home visits and had not yet started her preceptorship.

6.0.4 The NGHT IMR co-author reviewed the recommendations of two previous Serious Case Reviews which shared some similarities and learning points with the current review. The Cumbria: SCR (2005), and the associated NGHT action plan which highlighted that *"all staff must record personal details and relationships of persons present during all patient contacts."* A recommendation from the SCR concerning Maisie Harrison stated: *"The LSCB should reconsider how professional engagement with fathers can be more effective."*

7. Conclusions and Summary of what has been learnt

7.0.1 This Serious Case Review concludes that no professional, nor any extended family member, raised any child protection concerns for Leah Barnes before her admission to hospital on 8th May 2011.

7.0.2 Mark Dennis caused the death of Leah Barnes and there is evidence that several months before Leah was born Mark Dennis had declared to two doctors employed by the Army that he believed he was likely to harm his child if left alone with him. Neither doctor shared that information with Children's Social Care or the Army Welfare Service and this failure to ultimately share that information with civilian safeguarding agencies was a serious error as it denied those agencies the opportunity to fulfill their responsibilities to safeguard and promote Leah's welfare.

7.0.3 Had the information been shared, an initial or core assessment would almost certainly have been triggered and in turn highly relevant further information about the parental backgrounds would have been accessed. Measures may well have then been put in place which could have prevented Leah's death.

7.0.4 Despite this failure, there were other opportunities missed to learn more about Mark Dennis. Family histories and parental backgrounds are crucial to assessments about parenting capacity. A considerable amount of information was stored in Health Service files and databases about Mark Dennis's early years and troubled childhood, some of which would have been highly relevant to those assessing his parenting ability.

7.0.5 Despite his visible presence during the ante-natal period and at the birth of Leah, and despite his obvious physical disabilities, midwifery staff failed to take active steps to ascertain the identity of Leah's father or to offer him support. Midwifery staff at NGH did not 'Think Family' when they were providing a service to Leah and her mother, and this was contrary to the national guidance provided by the Nursing and Midwifery Council.

7.0.6 Leah had been seriously injured by the time of a 6 weekly checkup which was carried out by a Community Nurse on behalf of a Health Visitor. When the check was conducted Leah had several recent fractures to her ribs, arm, spine and leg, yet nothing untoward was noticed. The check was carried out in accordance with current service provision guidelines which may indicate that the current standard practice for conducting such checks is in need of review.

7.0.7 Although she was an experienced Paediatric Nurse, the Community Nurse who carried out the 6 week check had not received received specific training, or had been assessed regarding her competence, to carry out a 6 week development review. Furthermore she had not yet commenced her Preceptorship period which is designed to assist nurses into their new role.

7.0.8 A number of vulnerability factors were identified at the 6 week check, such as Della Barnes feeling low and Mark Dennis having serious injuries, and it was noted that Leah's weight had dropped from the 25th centile to the 9th centile. No steps were taken by the Health Visiting Team to meet with Mark Dennis and no concerns were raised in connection with the vulnerability factors. A plan was made to monitor Leah's weight over

a 4 week period but this was pre-empted by the catastrophic event which led to her admission a few days later.

7.0.9 The care provided by medical staff to Leah from the time she was admitted to A&E on 8th May 2011, until her death in Rainbows Hospice, was first class. The police criminal investigation was conducted in a highly professional manner and the Senior Investigating Officer provided a great deal of help to this SCR.

7.0.10 This Serious Case Review was not commenced until Leah died, many months after she received her injuries. A key element of such a review is to establish from professionals working with the family *why* things happened in the way they did. Due to the length of time that elapsed from their dealing with the family to them being asked to recall events, memories have faded and as a consequence the learning from this review is sub-optimal. To have achieved the best outcome in terms of learning lessons, this Serious Case Review should have been commissioned shortly after the 8th May 2011.

8 Recommendations for LSCBN

These recommendations should be read in conjunction with the Action Plan which provides detail about methods of implementation and timescales.

RECOMMENDATION 1

When children are presented to hospital with suspected non accidental injuries, the hospital staff should make simultaneous referrals to both social care and the police, and that LSCBN Child Protection Procedures should be amended to reflect this.

RECOMMENDATION 2

The LSCB should request that NGH and NHFT review their midwifery processes to ensure they explicitly contain an expectation that throughout the pregnancy and post natal period midwives and health visitors routinely continue to make active enquiries about the identity of the father of the unborn child, the parental relationships and

parental figures. The LSCB Chair should write to the Nursing and Midwifery Council to make them aware of the key issues relevant to them arising from this Serious Case Review.

RECOMMENDATION 3

The LSCB should convene a working party to explore the barriers to midwives and health visitors gathering information about fathers within families and supporting them. Through imaginative and mature multi agency discussion, the working party should actively look at ways in which any culture not to engage with fathers can be challenged.

RECOMMENDATION 4

A formal written handover between midwives and health visitors is essential to safeguard children. The LSCB should ensure the process for doing this is implemented and working seamlessly.

RECOMMENDATION 5

To ensure adequate safeguarding of children within military families there is a need to examine, and if necessary improve, training for military doctors and the information sharing arrangements between military medical and social work teams and their civilian counterparts. The LSCB Chair should write to the Ministry of Defence indicating that this Overview Report has significant lessons for the Armed Forces and that they should consider working with the material from the Armed Forces IMR to draw up a document outlining how the military should work in terms of safeguarding, safeguarding training specific to military medical personnel, and information sharing.

RECOMMENDATION 6

The LSCB Chair should write to the Department of Health and suggest they invite the relevant professional bodies, such as the Royal College of General Practitioners, to examine the case which triggered this serious case review and consider whether there are

further reasonable tests or steps which could be taken at the 6 week stage to determine whether a baby has suffered from gross injuries of the nature described in this report.

RECOMMENDATION 7

The LSCB should use the learning from this case to remind all agencies of the requirement that they should refer a case to LSCB if it meets the criteria for consideration of a Serious Case Review or other case learning.

RECOMMENDATION 8

LSCBN Child Protection Procedures should be amended slightly to include a specific responsibility on the LSCB agency delegates themselves to support any member of staff from their agency who feels a case may meet the SCR threshold. It should be the case that it is the responsibility of the LSCB delegate from any of the LSCB partner agencies to trigger consideration of a Serious Case Review if they feel the criteria are made out. The LSCBN Procedures should be amended to make this clear.

RECOMMENDATION 9

The LSCBN should refer the serious case review to the Adult Safeguarding Board so that they can consider whether there are any issues regarding the support for the adults involved in this SCR.

List of References

Brandon et al, (2009) *Understanding Serious Case Reviews and their Impact - A Biennial Analysis of Serious Case Reviews 2005 – 07*: London, DCSF

HM Government (2010) *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*, London: The Stationery Office.

Howe, D; Schofield, G; Brandon, M; Hinings, D (2009) *Attachment Theory, Child Maltreatment and Family Support*. Basingstoke: Palgrave Macmillan.

Laming, Lord (2003) *The Victoria Climbié Inquiry*, London: The Stationery Office.

Laming, Lord (2009) *The Protection of Children in England: A Progress Report*. HC 330, London: The Stationery Office.

Nursing and Midwifery Council (2012) *Midwives rules and standards 2012*

Paul, S P and Williamson, D M, (2010) *Journal of Family Health Care* Vol 22 - 6, 44-45

Robinson, S, Griffiths, P. (2009), *Preceptorship for newly qualified nurses: impacts, facilitators and constraints, Scoping Review*, National Nursing Research Unit, London: Kings College.

Uhing, M.R. (2005) Management of birth injuries. *Clinics in Perinatology*. 32:19–38

Appendix A

SERIOUS CASE REVIEW

LEAH BARNES

21.03.2011 - 07.11.2012

SCOPE & TERMS OF REFERENCE

1. Introduction

1.1. In accordance with the requirements set out in Working Together 2010, the Northamptonshire Local Safeguarding Children Board has decided to conduct a Serious Case Review into the circumstances in which Leah Barnes was seriously harmed on 8th May 2011 and subsequently died as a result of her injuries on 7th November 2012. Leah was 19 months old when she died (four weeks old when she was seriously harmed). Initial post mortem findings are not yet available but it is believed that her death was as a result due to breathing difficulties associated with her physical difficulties resulting from her injuries the post mortem report is awaited to confirm specific cause of death. It is believed therefore the criteria for a Serious Case Review, at 8.9 of Working together 2010, are met in that Leah died and abuse is suspected to be a factor in her death.

2. Decision to hold SCR

2.1. The case was referred to the Serious Case Review Committee on 6th December 2012 by Northamptonshire County Council Adults and Children's Services Specialist Looked After Service. The referral information was that Leah was born on 21st March 2011 with no significant issues at birth in terms of her health or physical wellbeing. She returned home with her parents and was monitored by universal services. At this point there was no social worker involved with the family. The family were initially supported by a community midwife who then transferred case to Health Visiting service as per standard process with no concerns. On 8th May 2011 Leah's parents presented Leah at Northampton General Hospital. The medical opinion on initial examination was that the injuries were non-accidental. Leah's injuries included a fracture to her skull, bleed on her brain, bleed on her spine, multiple retinal haemorrhages, multiple rib fractures, fracture to her right elbow, thoracic vertebral fractures. Leah remained in hospital for three months and moved to reside with her maternal grandparents on 24th July 2011. Since the injuries were sustained, Leah has had significant difficulties that have meant frequent periods in hospital as well as support via Rainbows Hospice based in Leicester. At the last Looked After Child Review 31.01.2012 the summary completed by social worker Julie Wright highlighted her health needs as:

As a result of her injuries Leah suffered from severe brain damage that is likely to leave her significantly and profoundly disabled for the rest of her life. Medical professionals have concluded that the brain damage that Leah suffered is as serious as is possible without causing death. In this respect, it is thought to be unlikely that Leah will make any significant progress as she grows older. Professional, independent paediatric medical reports have concluded that Leah's injuries were inflicted upon her deliberately and that they were sustained during four separate attacks....

As a result of her injuries, Leah is unable to swallow. She has had a gastric tube fitted in order that food can be fed to her intravenously and this will remain in place for the duration of her life time. Leah is currently suffering from Infant obesity. This is because Leah is unable to move physically, and also because she has very limited brain functioning. Leah is currently being fed a low fat milk formula. Leah's pain is now managed through a pain management plan which was formulated by Rainbows Hospice. Her long term prognosis is uncertain but at this stage it remains poor...

Prior to her death no improvements or changes to this were noted. Sadly on 7th November 2012, Leah died at Rainbows hospice.

2.2. Initial information requests were sent to all agencies on 20th November 2012 and this information was discussed alongside the referral form at the Serious Case Review Committee on 6th December 2012. The committee also heard information regarding the police investigation into the death and that the father had been arrested. As well as the concerns identified above the Serious Case Review Committee heard that Leah's father had informed his Army Medical Officer of his anger management problems and that he refused to be left alone with Leah's sibling Kiefer Barnes who was then aged 22 months. Information was also shared regarding evidence of items being smashed or damaged but not reported as potential domestic violence. In addition Leah's mother Della had told a health professional that her family felt she would not cope with her severely injured husband and two small children. This apparently did not result in any referral for assessment for additional support or of any risks that may have been posed.

2.3. The committee considered the case against the criteria set out in Chapter 8 of Working Together 2010 and agreed that as Leah had died and abuse was known to be a factor that it met the following criteria set out in paragraph 8.9:

"When a child dies (including death by suspected suicide) and abuse or neglect is known or suspected to be a factor in the death, the LSCB should always conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. In addition, a SCR should always be carried out when a child dies in custody, either in police

custody, on remand or following sentencing, in a Young Offender Institution (YOI), a Secure Training Centre (STC) or secure children's home, or where the child was detained under the Mental Health Act 2005."

It was also discussed that, had the case been referred to the Serious Case Review Committee following the initial incident in May 2011 it is likely that it would have met the criteria for consideration of a review under paragraphs 8.10 to 8.12 as a child had been seriously harmed as a result of abuse and there were concerns about how the agencies worked together. It was therefore unanimously agreed that a recommendation for a Serious Case Review should be made to the Independent Chair.

2.4 The formal recommendation for Serious Case Review was made to the LSCBN Independent Chair, Ms Janet Galley, on 17th December 2012. Her decision to conduct a Serious Case Review was notified to LSCBN 23rd December 2012 and was notified to DFE on 24th December 2012.

2.5 The Independent Chair was appointed on 25th January 2013 and the Overview Author on 23rd January 2013 respectively. This delay was due to seeking advice from with the National Association of Independent LSCB Chairs regarding identifying an Overview Author with suitable experience of working with Armed Forces and engaging with the MOD SCB. There was also a delay in identifying appropriate SCR Panel membership from an Armed Forces representative and their agreement to participate in the Panel was confirmed on 25th February 2013. The timescale for completing the SCR has therefore been adjusted accordingly. The terms of reference were agreed by the Independent Chair on 21st May 2013

2. Key Issues

- 3.1 The purpose of the Serious Case Review is as set out at Section 8.6 of Working Together (2010); namely:
- a. to establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
 - b. to identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and
 - c. improve intra and inter-agency working and better safeguard and promote the welfare of children.

- 3.2 Paragraph 8.39 of Working Together requires that agencies involved in a Serious Case Review should draw up Individual Management Reviews. These should be based on a comprehensive chronology of involvement by the organisation and/or professional(s) in contact with the children and family over the period of time set out in the review's terms of reference. (This chronology should clearly set out when the children were seen and, where age appropriate, whether the wishes and feelings of individual children were sought). They should briefly summarise decisions reached, the services offered and/or provided to the children) and family, and other action taken.
- 3.3 The Individual Management Review should consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken indicate that practice or management could be improved, IMRs should aim to get an understanding not only of what happened but why something did or did not happen. The nature of supervision across agencies should be addressed alongside frontline practice.
- 3.4 The historical information and the actions or inactions of agencies should be considered alongside the findings, recommendations and actions taken in response to previous Serious Case Reviews conducted by the LSCBN. New recommendations should only be made where there are significant differences in the findings from this review. This should be made clear in the overview report.
- 3.5 The Serious Case Reviews thought to be relevant in terms of prior learning and recommendations are LSCBN's SCR into Kieran Lloyd, Maisie Harrison, Child F and Cumbria SCB's SCR into Child JM. These recommendations are in relation to recognising the signs and symptoms of physical abuse, disability and parental vulnerability. The relevant recommendations, actions and resulting outcomes are appended as Appendix A.
- 3.6 The review will consider whether there was information which was known to agencies, or should have been known, that should have identified that Leah was at risk of harm. All agencies should consider the historical information they hold and if there is significant learning from this it should be appropriately referenced and brought into the review.
- 3.7 Issues which have been identified as requiring particular analysis in respect of the circumstances of this case are:
- It is a matter of concern that this case was not referred to Serious Case Review Committee following the serious and life threatening injuries sustained by Leah on 8 May 2011. The reasons why this did not happen will be addressed by the Overview Author together with any actions subsequently taken or required to prevent a similar occurrence in future.
 - The way in which agencies work together to identify concerns, share information and support armed service personnel living in localities and accessing a range of services across local authorities.

- What efforts were made by agencies to access information held by the armed services in relation to Leah's father's physical and mental health?
- To assess the impact of Leah's father's physical health, mental health and the apparent domestic violence on Leah's parents' ability to safely parent Leah and Kiefer and any potential risks that his contact with the children may have posed?
- What relevant historical information prior to Leah's birth was known to the agencies about the background and experiences of Leah's parents? Was this information effectively shared to ensure that appropriate decisions could be made to ensure she was protected from any known risks?
- Did the professionals working with Leah and her family have the required knowledge, skills and experience regarding the identification of and required response to possible child abuse and domestic violence? Were there any gaps in practice that may have impacted upon the outcomes for Leah?
- Children's Social Care to consider how the extended family's view of family functioning was used in their assessments and risk analysis.
- With hindsight what, if anything, could have been done differently and what impact, if any, such action may or may not have had on the outcomes for Leah?

3.8 Additionally, all IMR authors should also give consideration to issues listed in Working Together "scope and format of IMRs- analysis of involvement" which will also be the subject of consideration by the Overview Author. They are:

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were senior managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

3.9 The Individual Management Reviews and Overview Report will be anonymised in relation to this Serious Case Review by authors from the outset as set out in Appendix B.

3.10 Agencies are to consider whether lessons from previous Serious Case Reviews are being effectively learnt and put into action. They must in particular consider how far the learning from SCR's identified in paragraph 3.5 above. The commissioning and production of Individual Management Reviews must follow the Working Together guidance at paragraph 8.39 (March 2010) with particular attention being given to SMART recommendations and a comprehensive action plan. The Serious Case Review will identify good practice both in the Individual Management Reviews and in the Overview Report with a particular emphasis on robust risk assessment and decision making.

3. Time period over which events should be reviewed

4.1 The time period of this Serious Case Review is:

1st January 2009 to 7th November 2012

- 4.2 Agencies will need to consider the period from 1st January 2009, when Leah's mother was known to be pregnant with her first child Kiefer. This will allow us to consider how agencies supported this family through the birth of their first child. What did we know that may have led us to be concerned leading up to and after the birth of Leah.

This time period therefore has been chosen in consideration of the following factors:

- i) The date of Leah's birth on 23rd March 2011.
 - ii) The date of Leah's serious life threatening injuries coming to light on 8th May 2011.
 - iii) Leah's death on 7th November 2011
- 4.3 Individual Management Reviews should cover this time period as a minimum. Where there is additional involvement going back beyond these dates (e.g. within the parents' own childhoods) that is relevant to the review, agencies should provide a summary of their previous involvement within the Individual Management Review in the section Background. This should include a summary of early contact with the family relevant to the learning and the approach to multiagency working.
- 4.4 The SCR will not consider the detail of police investigations initiated as a result of Leah's significant injuries and subsequent death. The SCR Committee Chair will liaise as necessary with the police officers conducting that investigation.

4. Involvement of Family Members / Significant Others

- 5.1. Kevin Harrington the Independent Panel Chair will write to the parents and other relevant professionals working with them to advise them of the Serious Case Review being commissioned and to request consent for access to their records. Maggie Beer as the SCR Committee Chair has been given as their named point of contact. Where there are any issues in accessing adult health records this process will be taken forward by Jane Napier as the Health Overview Author.
- 5.2. Leah's parents will be given the opportunity to contribute their views directly to the Independent Overview Author by having a meeting if they are agreeable to doing so. As the parents are subject to a police investigation at this time, appropriate advice will be sought by the SCR Panel from professionals involved in this about how any meeting and feedback should be carried out, preserving independence and being sensitive to their needs as grieving parents. Arrangements will be made to offer them feedback at the end of the Serious Case Review process. Consideration will also be given to making contact with any significant other members of the family such as maternal grandparents who cared for Leah for much of her life.
- 5.3. Should there be any indication in the information gathering process that there is information and/or learning to be gained from the involvement or contribution of other family members this will be considered by the Serious Case Review Panel.

6. Ethnicity religion diversity and equalities / immigration issues

- 6.1 The members of the family are White British. As previously mentioned Leah's father suffered from physical disability due to injuries sustained during active military service. There are at this stage no reported issues of faith or religion.

The Individual Management Reviews and the Overview Report will consider issues of diversity and any relevant aspects of the social and economic environment in which this family lived.

7. Organisations to be involved in this SCR

7.1 The Serious Case Review Panel will ideally comprise of the following members.

- Independent Panel Chair
- Independent Overview Author (in attendance)
- Acting Head of Integrated Safeguarding and Quality Assurance Services
- Designated Doctor(in attendance)
- Northamptonshire Foundation Health Trust
- Northampton General Hospital Trust
- Northamptonshire Police
- Armed Forces representative
- Education representative
- SCR Committee Chair

7.2 The Panel includes agencies from whom Individual Management Reviews have been commissioned and others who are not directly involved but are able to provide further independent scrutiny from agencies directly involved in the case. The panel will be supported by the LSCBN Business Office team and the Designated Doctor who may refer on for any appropriate specialist medical advice needed.

7.3 The following organisations/services in Northamptonshire will be asked to submit Individual Management Reviews or, where indicated, Statements of Information:

- Nene and Corby Clinical Commissioning Groups (Health Overview Report)
- Northamptonshire Foundation Health Trust
- Northamptonshire GP Services
- Northampton General Hospital Trust
- Northamptonshire Police
- Children's Social Care, Northamptonshire County Council

- Education (IMR on the hypothesis of what they would have done)

The following organisations/services in Wiltshire & Devizes will be asked to submit Individual Management Reviews or, where indicated, Statements of Information:

- SIB, Military Police, Armed Forces

7.4 At this stage it is not known whether there are any relevant interests outside the main statutory organisations such as voluntary or independent organisations. Where the chronology shows that there is involvement the SCR Committee Chair will link with them as necessary to secure their involvement.

7.5 Should there be a failure to cooperate with the review this will be addressed by the Independent Chair with the relevant Board member or Chief Officer of the agency.

8. Involvement of organisations in other LSCB areas

8.1 It is known that there is involvement of organisations in Aldershot and Wiltshire & Devizes LSCB areas. Relevant involvement will be identified by the SCR Committee Chair who will take responsibility for ensuring that the LSCBN negotiates, manages and co-ordinates any other LSCB's involvement in the Serious Case Review process. The LSCBN Safeguarding Project Officer will take operational responsibility on a day-to-day basis being the point of contact between the Independent Chair and Overview Author and Northamptonshire. All contact will be via the LSCBN Business Office address.

8.2 The LSCBN will take the lead in conducting this review and will arrange a briefing for the Individual Management Review authors and will ensure that Commissioners are suitably briefed on the expectations of their authors. In order to complete the review within the mandatory timescales it is essential that timescales are adhered to.

8.3 If any matter relating to cross border working arises during the course of the review and remains unresolved the Independent Chair will seek to resolve the matter with any relevant LSCB. If an issue arises where resolution is not possible by these means the Corporate Director for Children, Communities and Education will address this with their counterpart.

9. Legal Advice

9.1 There are no issues requiring legal advice at present but the use of legal advice will be kept under constant consideration throughout the process of the Review.

10. Commissioning of an Independent Author & Chair

10.1 An Independent Panel Chair has been appointed who has no previous connection to any organisation that was or might have been involved in the management of the case. Kevin Harrington is an independent person with substantial experience of carrying out and contributing to SCRs. He will ensure that a robust and transparent Review is carried out and that timescales are strictly adhered to via a project management plan. He will also agree a quality assurance process with the Serious Case Review Panel.

- 10.2 An independent Overview Author has been appointed who has no previous connection to any organisation that was or might have been involved in the management of the case. John Fox is an independent overview author who has considerable experience of working within the safeguarding arena, specifically with LSCBs, conducting Serious Case Reviews and working with Armed Forces. He will draw together all the elements from the Individual Management Reviews, offer engagement with the family members and analyse professional practice into the Overview Report and Recommendations to the LSCBN. He will also provide guidance to the SCR Committee, IMR authors and commissioners on quality assurance of the IMRs.
- 10.3 The Overview Author should follow the guidance found at paragraph 8.40 of Working Together. Should the Board regard the report to be of poor quality or fail to ratify the final report there will be an agreed independent mediation process to resolve the issues. This will ensure that the final report meets the standards required by the LSCBN and also addresses the pertinent learning.

11. Expert Opinion

- 11.1 If the panel consider further specific expertise is identified they will take appropriate action in identifying a suitable expert.

12. Parallel Reviews

- 12.1 As stated above there is an ongoing Police investigation into the circumstances of Leah's death. The Police representative on the Serious Case Review Panel will provide updates on progress of the investigation at relevant stages in the process. The Serious Case Review Panel will continually have regard to this and have regular updates to inform the learning within their process. The Independent Chair of the SCR will maintain liaison with the Senior Investigating Officer throughout the Review as necessary.

13. Coroner's Inquiries/Criminal Investigations

- 13.1 The Coroner's Inquest has been opened and adjourned and routes of communication agreed between the SCR Committee Chair regarding the progress of the Inquest and Serious Case Review process.

14. Taking into account the relevant learning from research

- 14.1 Individual Management Review authors should review local and national research and learning including the Biennial analysis of Serious Case Reviews.

15. Media coverage/enquiries

- 15.1 There has been no known media coverage of the death of Leah. This will be kept under review to ensure that any public interest is appropriately managed before, during and after the review. The Communications & Engagement Committee is aware of the case and will develop a media strategy that reflects the sensitivities of the case.

15.2 The Serious Case Review Panel will consider how Leah's parents and other relevant family members will be informed of the findings of the Serious Case Review. At the conclusion of the Serious Review the LSCBN will, in line with government guidance, publish the Overview Report and the Executive Summary, unless there are exceptional circumstances which indicate that this would not be appropriate. Publication will be carried out in liaison with the Communications & Engagement Committee who will develop the media strategy as the Serious Case Review progresses.

16. SCR Timescales

23rd December 2012 – Decision by Independent Chair

23rd January 2013 – Appointment of Overview Author

25th January 2013 - Appointment of Independent Chair

22nd February 2013 – Meeting between Independent Panel Chair, Independent Author, SCR Committee Chair & Business Office

22nd February 2013 – IMR & SCR Briefing

22nd March 2013 – chronologies to be received into Business Office

15nd April 2013 – first draft of IMR's to be received into Business Office

16nd May 2013 – Panel meeting – presentation first drafts of IMR's to panel

w/c 10th June 2013 – IMR authors peer group

27th June 2013 – Panel meeting to consider first draft Heath Overview Report, second drafts of IMR's

Early July 2013 – Multi-agency recommendations and action planning meeting.

24th July - Panel meeting to consider IMR's and additional information, multi agency action plans

18th September – Panel meeting to consider final IMR's, first draft Overview Report, multi-agency action plans

30th October – Panel meeting to consider remainder final IMR's, final Overview Report, final Health Overview Report, multi-agency action plans

LSCBN Extra ordinary meeting to be scheduled start of December with submission date to DFE mid December 2013

16.1 As above a timetable has been scheduled according to the timeline attached at Appendix C with dates for the submission of the Individual Management Reviews,

Panel meetings, the presentation of the Overview Report to the LSCBN; and the submission of papers to the DfE is targeted for mid December 2013.

17. Liaison with DfE & Ofsted

17.1 Liaison with the DfE and Ofsted will be by the SCR Committee Chair based at John Dryden House, The Lakes, Northampton, NN4 7YD who will update the DfE on progress and liaise with them over any reasons for extension to the timescale

Appendix B

Letter of Notification to Parents

Dear [Insert Name]

Re:

Firstly I would like to offer my condolences on the death of [Insert Name].

or

Firstly I would like to acknowledge how difficult matters must be for you and your family at this present time.

The purpose of my letter is to inform you that the Local Safeguarding Children Board Northamptonshire has made the decision to undertake a Serious Case Review following the death of [Insert Name].

The purpose of a Serious Case Review is to establish if there are lessons that can be learnt by the agencies involved with [Insert Name] and your family and to help avoid such an incident happening in the future. Importantly, it will also help agencies understand how they can improve on working together.

I would like to reassure you that a Serious Case Review is not an inquiry into how [Insert Name] died/was injured or to lay any blame. The guidance we follow is laid down by government in a document called *Working Together to Safeguard Children (March 2010)*.

Each local authority and agencies that have been involved with you are required to write a report about the work they carried out with you and your family. These reports will be presented to a Serious Case Review meeting which has an Independent Chair. An Overview Report will be completed by an Independent Overview Author which will bring together and analyse the findings of the various reports and make recommendations about how agencies may work together in the future. A summary of the report will be made public once it has been finalised, however it will not contain any of your personal details so you will not be able to be identified.

As part of this review I would like to offer you the opportunity to contribute to the report and to ensure your views are included and give you the opportunity to meet with the Independent Overview Author if you so wish. I would like to stress that the Serious Case Review is a separate and independent process from any other work and involves senior managers from agencies that make up the Local Safeguarding Children Board in Northamptonshire as well as the Independent Chair and author as outlined above

In order to undertake the review we will ask for information about your family from the agencies that know you. This means that we will need to look at your personal files including your health files from hospital and general practice. The reason for doing this is to understand if there are any factors in the background or in the response to any problems that may have had any influence on the events.

As well as looking at your own personal files we also wish to look at the files relating directly to [Insert Name] and would like your consent to do this. I would be grateful if you would complete and return the attached consent form. I do understand that this must be difficult for you. If you have any queries regarding giving consent to access your medical records please contact [Insert Name], LSCBN Standards Research & Development Manager on the number below in the first instance.

I apologise if this letter and the Serious Case Review process is upsetting for you, however I hope you will appreciate and agree that this process needs to occur to ensure there is some learning from the event that has occurred. [Insert Name], as the Independent Overview Author, will contact you soon to arrange a time to seek your views and to further explain the process in more detail, if there is anything you would like to know or you would like to speak to someone please contact [Insert Name] in the first instance.

Please respond to this letter by [insert date] and I enclose a self addressed envelope for your reply.

Yours sincerely

[Insert Name]

Independent Chair

Serious Case Review Panel