

# The Overview Report into a Serious Case Review of the circumstances concerning:

Child Q

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**The family structure during the Review period**

Child Q	F	Subject
Mother	F	
Father	M	
Maternal Grandmother	F	

# **1. Introduction**

## **1.1 Who was Child Q?**

*1.1.1* At the time of her death Child Q was a 7 month old girl who lived with her Mother in a small modern 3 bedroom house in a town in Northamptonshire, which was temporary accommodation for the family. The Serious Case Review Panel was informed Child Q's Father was sent to prison when she was 3 months old, however Child Q's Father was clear she was 19 days old – *please refer to paragraph 2.9.3.*

*1.1.2* Child Q was born in hospital. The birth was uncomplicated and she was a healthy baby until the events which precipitated this Review.

*1.1.3* A Health Visitor who visited Child Q at home described the house as '*perfect*' and Child Q was described by her Health Visitor as a '*happy alert baby, interacting well with her Mother*'. Child Q's view of the world was consistently recorded as '*happy and content*'.

*1.1.4* There were also two dogs living in the house at the time of the incident and they were usually kept in separate cages in the kitchen. One of the dogs was an aggressive Pit Bull type dog.

EXPLANATORY NOTE: The reason this Overview Report refers to the dog as a 'Pit Bull Type' is because the Pit Bull, or American Pit Bull Terrier, has never been recognised by the Kennel Club in the United Kingdom. This type of dog is a cross breed that can be created by interbreeding any number of breeds to achieve a dog that looks like a Pit Bull (most usually a Staffordshire bull terrier with any number of mastiff breeds).

Section 1 of the Dangerous Dogs Act 1991 makes it a criminal offence to possess any dog of the type known as the pit bull terrier and three other named dogs, (Japanese Tosa, Dogo Argentino and Fila Brasileiro) which the Act also refers to as type rather than breed. This is because 'type' has a wider meaning than 'breed' (R v Knightsbridge Crown Court ex parte Dunne). The only way to determine whether a dog is a banned breed is by way of expert examination using various measurements, or by post-mortem examination.

## **1.2 Brief Summary of Circumstances Leading to the Review**

*1.2.1* The case in question was triggered by the death of Child Q on 3rd October 2014.

1.2.2 During that evening Child Q was at home being cared for by her Grandmother. Child Q was sleeping in a Moses basket in the living room. There were also two dogs living in the household and one was a particularly aggressive Pit Bull type dog. The concurrent Police investigation has discovered that the latter dog, was purchased by Child Q's Mother and it was her decision to allow the dog to live in the family home. The dogs were usually kept in separate cages in the kitchen of the house. At the time of the incident a dog was locked in one cage and it was reported that the dog was in the other cage which had a faulty lock.

1.2.3 At 22.38 hours a call was received by Police, from the Grandmother. She was in an hysterical state and told the Police Control Room Operator that one of the dogs had escaped into the lounge and attacked Child Q as she lay in her basket.

1.2.4 Two Police Officers arrived at the house within 5 minutes. The dog still had Child Q's head in its jaws yet they managed to subdue the dog and remove it to the kitchen. Child Q's injuries were so severe that, despite attempts by the officers at resuscitation, she died.

1.2.5 The attack by the dog was so ferocious that Child Q received a number of deep lacerations to the scalp many of them down to the skull bone itself, and in addition the dog had bitten through her skull, causing extensive bleeding to blood vessels around the brain. With this level of injury, particularly the bleeding into the brain space, it is the view of an A&E Consultant who provided an emergency response to her home that there was no chance whatsoever that she could have survived the attack, irrespective of how quickly first aid was commenced. This concurred with the view of a Pathologist that she would have died within one minute of the bite to her head.

1.2.6 It is important for this Overview Report to acknowledge, and highlight, the bravery and professionalism of the two Police Officers who successfully stopped the dog from continuing its attack on Child Q and her Grandmother. The scene they were presented with was nothing short of catastrophic. The officers were not equipped with any specialist dog catching equipment yet with little regard for their own safety they managed to separate the dog from the child and force it into the kitchen. They then immediately began attempts at resuscitating Child Q despite the obvious devastating injuries which were present. The two officers continued to try and revive her until a paramedic arrived at the house several minutes later.

1.2.7 A Serious Case Review (SCR) is not concerned with establishing culpability however it is of note that the Crown Prosecution Service (CPS) decided to prosecute Child Q's Mother and Grandmother for being in charge of a dangerously out of control dog which killed a child. In order to reach that conclusion, the CPS had to believe that there was a realistic prospect of conviction which was 'beyond reasonable doubt'. The analysis in this Overview Report is therefore underpinned by a belief that Child Q's carers failed in their duty to protect her from a dangerous hazard within the home.

## **2. Process of the Review**

### **2.1 The Statutory Basis for Conducting a Serious Case Review**

2.1.1 The role and function of a Local Safeguarding Children Board (LSCB) 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 in accordance with guidance set out in Section 4 of Working Together to Safeguard Children (2013 and 2015). The mandatory criteria for carrying out a Serious Case Review include where –

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

(b) (i) the child has died;

2.1.2 In this case, Child Q has died and the charging decision by the CPS indicates a failure to properly protect her, therefore neglect is suspected.

2.1.3 The product of the Review, known as the Overview Report, is sent to the Department for Education (DfE). All Reviews of cases meeting the SCR criteria must result in a report which is published.

2.1.4 A Serious Case Review should be conducted in a way which recognises the complex circumstances in which professionals work together to safeguard children and seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did.

2.1.5 LSCBs may use any learning model which is consistent with these principles, including the systems methodology. Having decided to undertake a Serious Case Review to look at how well agencies were working together to support Child Q and her family it was decided to implement the systems methodology using a blended approach, taking elements of the process and coverage set out in *Working Together 2010* and combining this with the focus on learning and public accountability encouraged in *Working Together 2013 and 2015*. This has been done to build on current arrangements and experience for producing Individual Management Reviews (IMR) and robust individual analysis by each involved agency, but adding the greater involvement of practitioners and clinicians and encouraging reflection and learning from the circumstances and context of the case.

## **2.2 The Commissioning Arrangements**

2.2.1 The standing Northamptonshire Safeguarding Children Board (NSCB) Serious Case Review (SCR) Sub Group convened on 8<sup>th</sup> January 2015 and recommended that the threshold had been met to necessitate a Serious Case Review under Section 4 of the Statutory Guidance *Working Together to Safeguard Children* (2013).

2.2.2 Usually the decision to commission an SCR should be made within one month of the incident precipitating it. In this case the circumstances were presented to the SCR Sub Group on 6<sup>th</sup> November 2014 and again on 4<sup>th</sup> December 2014 but at both meetings further information was required and therefore a recommendation to the Independent NSCB Chair could not be made until all the information was available in January 2015.

2.2.3 This recommendation was endorsed by the Independent NSCB Chair on 5<sup>th</sup> February 2015 and he instructed that a 'focused and proportionate' SCR be conducted. To that end, very strict timescales were imposed for the period under Review, these being 1 October 2013 to 3 October 2014 (the date of Child Q's death).

## **2.3 Independence**

2.3.1 *Working Together to Safeguard Children* (2013) also mandated that Reviews of serious cases should be led by individuals who are independent of the case under Review and of the organisations whose actions are being Reviewed. The LSCB should appoint one or more suitable individuals to lead the SCR who have demonstrated that they are qualified to conduct Reviews using the approach set out in this guidance. To ensure transparency, and to enhance public and family confidence in the process, the NSCB Chair appointed an independent person to lead this SCR and write the Overview Report.

## **John Fox MSc, PhD. – Independent Lead Reviewer and Author**

2.3.2 John Fox was responsible for analysing the professional practice of professionals and organisations and making recommendations to the NSCB for further action to better safeguard children.

2.3.3 He has had no involvement directly or indirectly with the children 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.

2.3.4 John Fox is a Senior Lecturer at the University of Portsmouth and previously was Head of Child Abuse Investigation in a large Police Force. From 2001 - 2003 he was the Police Advisor on the Victoria Climbié Statutory Inquiry. He has conducted many SCRs as Independent Overview Report Author, is trained in SCIE and SILP systems Review methodology, and has completed the 2010 NCH/NSPCC national training for SCR authors.

## **2.4 The SCR Panel**

2.4.1 The dedicated Serious Case Review Panel was chaired by Maggie Beer a senior and experienced social work manager from within Northamptonshire Children Families and Education Services.

2.4.2 Panel membership was as follows:

Designated Nurse for Safeguarding Children & Looked After Children, Clinical Commissioning Groups
Head of Safeguarding Children and Multi-Agency Safeguarding Hub, Healthcare Foundation Trust
Head of Protecting Vulnerable Persons, Police
Dog Legislation Officer (East Midlands Operational Support Service)
Head of Companion Animals Department, RSPCA
Safeguarding Project Officer, NSCB
Administrator, NSCB

## 2.5 Agency IMR Reports

2.5.1 Although agency specific Individual Management Reviews (IMRs) are no longer required under Government guidance, the NSCB process still includes them as part of the blended approach.

2.5.2 The process 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. The people preparing the individual agency IMR reports for this Review were all approved by the Independent Lead Reviewer, as being senior personnel within each agency who were completely independent of any involvement or line management responsibilities concerning the case.

2.5.3 The SCR Panel decided that the following agencies and organisations would be asked to contribute to the learning of this Review.

<b>IMR report provided by:</b>
NHS England - General Practitioner
General Hospital (Midwives)
Police
Healthcare Foundation Trust
Royal Society for the Prevention of Cruelty to Animals (RSPCA)

<b>Statement of Information provided by:</b>
Regional Ambulance Service
Children's Social Care
Local District Council
Local Borough Council
General Hospital (A&E)
Education



2.5.4 The NSCB provided each agency 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 focused on the areas required by the Terms of Reference. Each individual agency report author was invited to present their report to the SCR Panel where any clarification was provided, or additional work requested.

## **2.6 The Practitioner Event**

2.6.1 To ensure that practitioners involved in the case were fully involved in the SCR learning a practitioner's event was held on 18<sup>th</sup> November 2015. Practitioners from each agency which provided a service to Child Q and her family were invited to attend the event, as were the SCR Panel Members, IMR Authors, and Lead Reviewer.

2.6.2 On the day, 8 practitioners attended. Their valuable contributions were recorded by the NSCB Safeguarding Project Officer, and those contributions helped inform the learning and analysis in this Overview Report. It is disappointing that none of the frontline Police practitioners were permitted by their Force to attend the learning event and this restricted the understanding and the learning opportunities in respect of the serious incident during which Child Q died.

## **2.7 Scope and Terms of Reference**

2.7.1 The full Terms of Reference and Scope for the Review are attached at Appendix A.

2.7.2 The Terms of Reference were discussed and agreed at the first SCR Panel meeting. They were then ratified by the Independent Chair of the NSCB and thereafter became the instructions to the Independent Reviewer about the scope required for the Review.

## **2.8 The delay in finalising this SCR**

2.8.1 In their 2015 annual report, the National Panel of Independent Experts on Serious Case Reviews were critical of the fact that many SCRs were not being completed within the appropriate timescale.

*"The panel is also concerned about delays. Many SCRs still seem to take a very long time to progress to conclusion and publication."*

2.8.2 The statutory guidance on the conduct of SCRs, *Working Together to Safeguard Children* (2015) is quite clear about the need for such Reviews to be completed quickly:

*"The LSCB should aim for completion of an SCR within six months of initiating it."*

2.8.3 This SCR was not completed within the timescales set out by the Government and, in fact, because of a perceived conflict with the criminal proceedings, the opportunity to gather all relevant learning for this Review was either blocked, or delayed by several months. As discussed above, the Practitioners Learning Event is the primary opportunity for front line professionals to meet with the Lead Reviewer and the SCR Panel to attempt to establish the answers to the 'why' question. This is a hugely important part of a systems type Review and any disruption to the timetable for this event should only be for the gravest of reasons.

2.8.4 The Practitioners Learning Event for this Review was originally set to take place on 3rd June 2015. Since this would have been the final piece of the jigsaw in terms of gathering evidence for the Review it is likely that the *Working Together* timescales could have been met had that meeting gone ahead.

2.8.5 However, 5 days before that event the Police Senior Investigating Officer sent an email to the NSCB Business Office saying, *"...my preference would be not to hold a learning event until we know the outcome of the CPS decision"* (This was now 7 months after Child Q had died).

2.8.6 Since the Police were unable to provide any convincing reasons why going ahead with the event may potentially prejudice the related court proceedings the NSCB initially decided that the event would take place as planned. However, it quickly became apparent that the Police would not allow their staff to attend, and they did not want anyone else who had made a written witness statement to attend either.

2.8.7 This placed the Board in a very difficult position because if the event had gone ahead several delegates such as the Health Visitors, if they had attended at all, would probably have been very confused about how much contribution they could make. Consequently, the NSCB had no alternative but to bow to the pressure from the Police and postpone the Learning Event until later in the year. In the event, when the Learning Event was held in November 2015, the case had still not gone to trial so it is difficult to see what difference it made to postpone the event in June because very little had changed in terms of court proceedings.

2.8.8 It should be noted that although the Police acted as the direct interface between the criminal justice sector and the NSCB office, behind the scenes the Crown Prosecution Service were undoubtedly putting pressure on the Police Senior Investigating Officer to request a delay to the learning event, and it was their very lengthy decision making process regarding possible charges which may well have been a contributory factor.

2.8.9 It should also be noted that the Crown Prosecution Service and the National Police Chiefs Council (formerly ACPO) have produced joint guidance<sup>1</sup> on conducting SCRs when there are concurrent criminal proceedings. It is recognised in that document that many professionals may be asked to make a witness statement but will not be 'key' witnesses in any trial. As such, the guidance to the Crown Prosecution Service and Police is as follows:

*"It is unlikely that the presence of such witnesses at a practitioner's event would make a difference to the criminal case so it is unhelpful and disproportionate for the criminal justice agencies to simply seek to exclude anyone who could be a potential witness from contributing learning to a serious case Review."*

2.8.10 The request by the Police to postpone the Learning Event in this case delayed the SCR for several months, and it now seems that the delay was unnecessary. It is clearly not in anyone's interest that a criminal case is compromised but in the foreseeable future there is likely to be increased scrutiny by the Government concerning the reasons for any delay to SCRs. Therefore, in respect of any SCRs commissioned in the future, NSCB should make it clear to all constituent agencies that they will require compelling reasons to be given in writing, from any agency which seeks to disrupt the business or the timescales of the Review, and that the Independent NSCB Chair will be the final decision maker. **Recommendation 1**

## **2.9 The Voice of the Family and Significant Others**

2.9.1 The statutory guidance *Working Together* (2015) requires that families, including surviving children, should be invited to contribute to Reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. A commitment to providing the fullest opportunity for the family to be invited to participate in the Review was agreed at the first Panel meeting.

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<sup>1</sup> Association of Chief Police Officers/Crown Prosecution Service (2014) *Liaison and information exchange when criminal proceedings coincide with Chapter Four Serious Case Reviews or Welsh Child Practice Reviews*

2.9.2 Unsuccessful attempts have been made to contact the parents to engage in the SCR process, but those attempts were halted by the NSCB because having made their charging decision the CPS subsequently requested that no contact is made with either Child Q's Mother or Maternal Grandmother. This is another example whereby the work of the SCR has been potentially compromised. It is not clear whether or not the family would have agreed to contribute to the Review anyway but the restriction requested by the CPS, and the consequent agreement by the NSCB, has meant that a key principle required by *Working Together to Safeguard Children* (involving the family in the SCR process) has not been adhered to in this case.

2.9.3 Following the conclusion of the criminal process the Panel Chair and a Panel Member again attempted to contact the parents to discuss the publication of the Serious Case Review. They were successful in making contact with Father and Paternal Grandmother. The Father made it clear that he did not own the dog and that he had been sent to prison when Child Q was 19 days old, not 3 months old as previously reported. The Father stated that prior to being sent to prison he had insisted on the 2 dogs being re-homed to a relative when Child Q was 2 days old. He states he was unaware that the dogs had been returned to the household. Clearly this is the Father's account and cannot be verified.

2.9.4 The Mother and Maternal Grandmother were also seen, in Prison, to discuss the publication of the Serious Case Review.

### 3. 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 child. Since the Review is primarily concerned with Child Q, only events which may have affected her, or the capacity for adults to look after her, have been included in this section.

#### 3.1 Significant events before Child Q was born

3.1.1 Police records show a history of domestic abuse between Child Q's Maternal Grandmother and her long term partner, Child Q's Maternal Grandfather. The information also shows that there were welfare concerns in respect of their children, which included Child Q's Mother.

Police

3.1.2 Police have also attended Domestic Incidents involving Maternal Grandmother where she has been both the perpetrator and victim. In many of the incidents Maternal Grandmother is under the influence of alcohol.

Police

3.1.3 Between 2009 and 2014 the GP has recorded 'Many accounts of alcohol problems, depression' in relation to Maternal Grandmother.

GP

3.1.4 On the 22nd May 2008 Police attended Maternal Grandmother's home because she reported that she believed that a puppy she had bought could be of a banned type. A further call was received by her sister to say that she had been bitten by the dog. Officers attended the address and Maternal Grandmother was initially very aggressive toward the officers.

Police

3.1.5 Police have recorded a history of domestic incidents between Mother and her parents. Both parents have been arrested for assaulting Mother but she has always refused to support Police action. The Police also have a history of domestic incidents involving Mother and a previous boyfriend who is a cocaine user whereby he both verbally and physically abused her.

Police

3.1.6 On 27th May 2009, when she was 16, Mother left her Mother's home having been 'kicked out'. During a conversation with a social worker she described her Mother as an alcoholic.

CSC

3.1.7 Child Q's Father is recorded as attending hospital on several occasions due to alcohol and drug related problems. He is also known to the Police for offences of violence.

### 3.2 The Relevant Period of the Review

3.2.1 On 27th August 2013, Mother attended the GP surgery to inform them of her pregnancy with Child Q and to make a booking appointment with the Midwife. The Midwife recorded that this was '*a low risk pregnancy*'.

Midwifery

3.2.2 On 17th January 2014 Mother took a pit bull type dog to a Vet for treatment. The Vet was concerned that the dog was a banned type and informed the RSPCA who made an onward referral to the Police. The Police intelligence report noted, "*Intelligence suggests that (Mother) owns a suspected pit bull type dog. This is believed to have been treated by a vet. The dog is described as aggressive to other dogs and the vet.*" The referral from the Vet and RSPCA did not mention the fact that Mother was pregnant but at the time she took the dog to the Vet she would have been about six months pregnant with Child Q.

Police

3.2.3 Child Q was born in hospital on 27th March 2014. Father and Maternal Grandmother were both at the hospital for the birth. There were no complications and the family were discharged home later the same day. Child Q's notes state "*(Child Q) well, parents confident with care of baby.*"

Midwifery

3.2.4 On 9th April 2014 a Health Visitor from the local Health Visiting Team, visited the home for the Primary Birth Visit. Child Q was 12 days old. The Health Visitor carried out a detailed assessment of Child Q, using a hands-on approach, which involved handling, undressing and weighing her naked. The Health Visitor had no health concerns for Child Q and she recalled during interview, her Mother being like a "*doll, perfectly made up, polite and interested in what (Health Visitor) had to say*".

HFT

3.2.5 Child Q only attended the GP surgery once during her life and this was on 6th May 2014. She was noted to have a rash on her face. The GP reassured her Mother and recorded, '*Mum not experienced and quite anxious but coping very well with good family support. Very interactive baby, looking at Mum and smiling readily.*'

GP

3.2.6 On 9th May 2014 the local District Council received a barking dog complaint from a neighbour of Child Q. No home visit was undertaken but as is usual practice a standard letter was sent to the owner/occupier at Child Q's home alerting them to the complaint and asking for cooperation to reduce unreasonable noise levels.

DC

3.2.7 In June 2014 Father was sent to prison where he remained until after Child Q's death – *please see Paragraph 2.9.3 as Father disputes this date.*

3.2.8 On 21st July 2014 a Health Visitor attended Child Q's home to carry out a routine 3/4 month visit. A holistic assessment was conducted and no needs or risk factors were identified. It was noted that Mother had good social and family support and she was seen to be responding to baby's needs, with good attachment seen between baby and Mother. No concerns regarding housing were identified. Child Q had achieved good developmental milestones. The Health Visitor became aware on this visit that there were two dogs within the home, but she did not actually see the dogs or make enquiries about them with the Mother and she noted, '*No concerns raised in regards to home environment.*'

3.2.9 At 11:32 hrs on 21st August 2014 Police officers were deployed to Child Q's home because of a report that Maternal Grandmother had turned up at the house in a drunken state and assaulted her daughter (Mother). Mother told the officers that Maternal Grandmother was very intoxicated with alcohol and she didn't want her around the baby, Mother had tried to remove the alcohol from her Mother who had pushed her then pulled her hair and scratched her. The officer noted that Child Q was present but '*did not appear to be phased by it*'. The officer observed that the baby appeared to be fit and healthy and he had no concerns of the Mother's ability to look after her, the officer only had limited access to the house but he was of the opinion that the premises were suitable for a child. Mother refused to make a complaint of assault and Maternal Grandmother was escorted away from the premises by the officers. The Police Officers did not notice any dogs in the house.

3.2.10 The following day, on 22nd August 2014, Mother took Child Q to the Accident and Emergency as Child Q was not using her right arm. A pulled arm was diagnosed and Child Q was discharged on the same day following manipulation of the limb. No safeguarding concerns were identified by the A&E doctor and the reported mechanism of injury was accepted as plausible (reported that Child Q had pulled away during a feed and Mother grabbed her baby grow in order to prevent Child Q from falling).

HFT

Police

HFT

3.2.11 On 3<sup>rd</sup> October 2014 Mother went out for the evening to socialise and left Child Q in the care of Maternal Grandmother. At 22:38 hours a call was received by Police, from a distressed female who was later identified as being Maternal Grandmother. She said that one of the dogs had attacked and killed Child Q. Police Officers attended the house, separated the dog from Child Q and attempted resuscitation. The injuries to Child Q were so severe that she died during the attack. An A&E Consultant who works part time for the regional Ambulance Service as a first responder, examined Child Q at the scene and declared her dead at 23:08.

Police  
Ambulance Service

3.2.12 Child Q was taken to the local Accident and Emergency Department by ambulance. Maternal Grandmother arrived at A&E at around 01:00 and there were concerns passed on by paramedics that she was intoxicated when they treated her at the house. Child Q's Mother arrived at A&E at 01:35.

## **4. A Day in the life of Child Q and her family**

4.01 As far as is known, Child Q was a happy child. All the indications from those professionals visiting her at home were that she was clean and well cared for every day, and the house she lived in was modern, fairly spacious, clean and tidy. There was a small back garden which Child Q may have been taken into on warmer days.

4.02 A Health Visitor noted a very positive interpretation of what a day in Child Q's life was like, and described her as "*a very socially interactive baby, looking and smiling at mum*".

4.03 There were occasions however when Child Q would have been upset by traumatic events going on in her home. On one occasion when she was 5 months old her Grandmother and Mother had a fight and the Police were called. There would have been shouting and an aggressive atmosphere in the home during that incident which the Police say Child Q witnessed.

4.04 Child Q knew her Father from birth because he actually attended hospital and cut her umbilical cord. It is believed her Father lived within the household, however, their relationship and bonding was cut short when he was sent to Prison. Despite her young age, this would have been a change for Child Q.

4.05 In interview (*please refer to paragraph 2.9.3*), Child Q's Father confirmed that the Mother took Child Q to visit him in Prison on a couple of occasions.



## **5. Analysis of Key Episodes and the Lessons Learnt**

5.0.1 The particular circumstances leading to this SCR are highly unusual in the sense that dog attacks causing child fatalities are, fortunately, very rare in England. Although the dog undoubtedly killed Child Q this SCR is still focused on identifying whether the services provided to the family were adequate, and whether anything could have been done by professionals to predict or prevent her death.

5.0.2 Although it has since been confirmed that the dog was a banned type, and it is reported that the dog had previously exhibited aggressive behaviour towards people, it is unreasonable and unrealistic to expect universal service professionals such as Midwives and Health Visitors to be proficient in identifying dangerous types or breeds of dogs especially when breed or type is not a reliable predictor of aggressive behaviour. It is also unreasonable for them to necessarily know how dogs should be kept and cared for or to give specific advice around a dog's behaviour.

5.0.3 In order to avoid the Review straying from the key aims, the Lead Reviewer agreed with the SCR Panel that best practice in care and control of a dog should not become the main issue, but rather the dog should be considered in the same way as any other safeguarding hazard within a household, for example an open fire with a toddler nearby. In other words, the key question for the Review was whether professionals working with the family could, or should, have identified *any* safeguarding hazards to which Child Q was exposed.

5.0.4 These key issues are discussed during this section but the headline result of the analysis of the available information is that this Serious Case Review has revealed no evidence that during her life any agency or individual expressed any specific concerns for Child Q'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 Police Officers on one occasion. Social Workers within Northamptonshire County Council Children Families and Education Directorate had no direct involvement with Child Q during the period under Review and she had never been referred to the Police for reasons of safeguarding.

5.0.5 During her examination in A&E after her death, no old injuries were discovered, she appeared well nourished, and there was no evidence of parental abuse. It is therefore likely that the only occasion Child Q suffered any harm was during the single dog attack on the 3rd October 2014 which quickly led to her death.

5.0.6 The focus of this Review is on Child Q and her welfare, and this analysis will concentrate upon the following case specific questions prescribed by the Terms of Reference:

### **Capacity of carers to safeguard the child**

What did professionals know about the Mother and Maternal Grandmother and their likely capacity to be able to safeguard the baby from any hazard within the home, and what did professionals do with this information?

### **What was known about the dog**

What did / didn't agencies do to safeguard the child knowing a dog was in the property and was subsequently identified to be a dog which exhibited aggressive behaviour towards other people and dogs and of a banned type?

5.0.7 The remainder of this analysis section covers 5 key learning periods and will examine whether there was any reasonable possibility that an agency or individual professional could or should have been able to predict the events which occurred on 3rd October 2014.

## **5.1 Pre Birth and Maternity Unit Care**

5.1.1 Mother attended her ante-natal booking appointment at the GP surgery on 27th August 2013. Child Q's Father was also present. No concerns were noted by the Midwife and the pregnancy was considered as a 'low obstetric risk'.

5.1.2 The records concerning this appointment show that Mother was asked by the Midwife most of the required questions in the 'ante-natal care pathway' plan.

5.1.3 However, it is of note that a section of the form concerning '*plans for pregnancy and parenthood*' was not fully completed by the Midwife. The pathway uses a tick box format to check that there has been a discussion about each individual element and the areas not ticked included:

- Feelings about pregnancy
- Stresses in pregnancy
- Support at home

5.1.4 Both Maternal Grandmother and Father had long standing problems with alcohol which Mother must have known about. This information would have been relevant to Midwives and it could be speculated that had the Midwife at the ante-natal booking completed the '*plans for pregnancy and parenthood*' questions on stresses and support Mother may have revealed this information. However, it is now known that Mother was not always honest with professionals and therefore it is over-optimistic to suggest that she may have simply volunteered any information about alcohol dependency within her family.

5.1.5 The ante-natal pathway documentation also indicates that the required section '*preparing for your new baby*' was not completed by the Midwife. This section has the following areas that should be discussed, and which are of relevance to this analysis of practice:

- Home environment
- Equipment safe sleeping

5.1.6 The Hospital IMR Author feels that had this section been discussed with the parents it would have provided the possibility to explore what the home environment was actually like, and this may have led to a discussion around parental relationships, pets, and extended family relationships.

5.1.7 Had the Midwife considered that Mother may need extra support to cope with Child Q, the expected practice would have been to undertake a risk assessment using the Northamptonshire multi-agency '*Thresholds and Pathways Guidance*' which would have then indicated a course of action dependent on the level of need and risk identified.

5.1.8 On the face of it this was a missed opportunity to trigger further enquiries into Child Q's home circumstances but when attempting to establish why some of the relevant information appears not to have been gathered at the ante-natal booking appointment the Midwife informed the IMR Reviewer that she routinely covers all of the ante natal pathway assessment, however she agreed that as the boxes were not ticked she could not evidence this. It is possible therefore that all questions within the ante-natal pathway documentation were in fact asked, and it was just the paperwork which was not properly completed. Either way, no risk assessment was undertaken, or felt by Midwives to be required.

5.1.9 Both Father and Maternal Grandmother had been admitted to the local Hospital A&E on a number of occasions because of alcohol related problems. Even though Mother appears not to have volunteered information to the Midwife about their alcohol dependency the information indicating this was already available within hospital records. The fact that the Midwives were not aware that a primary carer for Child Q had a history of violence and alcohol issues was partly because they did not access the records created within their own hospital, albeit in a different department of the hospital. There is no legal reason why hospital staff cannot access patient's records as long as this is done for relevant professional reasons. In the same way that Midwives should be routinely curious about a Mother's ability to care for and support a child, so should they be routinely curious about the Father if it is clear (as it was in this case) that he will also be a primary and active carer.

5.1.10 Previous SCRs in Northamptonshire (e.g. Child J, 2014; Child I, 2012) have commented about a misplaced perception that Midwives cannot access the notes of the Father of a baby. It appears that the lessons from those SCRs may not have been fully understood by all staff because at the Professionals Learning Event for the current Review the same misplaced perceptions were evident.

5.1.11 An in depth discussion took place at the Learning Event about the fact that Hospital had records of Child Q's Father attending A&E on several occasions having received injuries from fighting, as well as several admissions dating back to 2006 for binge drinking and drug overdoses - yet the Midwifery Team in that same hospital did not know any of this. It is, of course, incumbent on A&E medical and nursing staff to be aware of any child safeguarding issues which may be present in respect of their patients and it is encouraging to note that a lot of work has already taken place within the hospital regarding A&E staff identifying if people have caring responsibilities when being admitted to hospital, with appropriate training being provided to professionals and appropriate forms updated.

5.1.12 Midwives at the Learning Event indicated that in Northamptonshire they believe there are 'strict rules' around checking a Father's history, and that a Midwife should only access it if there is a safeguarding concern. In this case, there were no concerns and no alarms were raised which might have led professionals to feel the need to check the Father's records.

5.1.13 Lord Laming (2003) said, "*Child protection cases do not always come labelled as such. Good communication and checking with partner agencies, must be the main way to decide how best to safeguard and promote a child's welfare*". In other words, Laming was telling professionals that in many cases you will only know if there is a safeguarding concern by accessing information about the carers of a child.

5.1.14 The SCR Overview Report concerning Child I (2012) noted that

*"If there is a perception amongst Midwives that they are not able to access paternal notes then this perception is wrong, and should be dispelled. Hospital staff can access paternal notes if necessary – with or without consent. The Data Protection Act is not relevant and any perception that this is a blockage to accessing the Fathers' information should be of great concern to the LSCB and its constituent agencies."*

5.1.15 It is worth revisiting the basis upon which this comment was made. 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)

5.1.16 In the case of Child Q, her Father was visible at the ante natal appointments, and at the birth, so there should have been no doubt that he was going to be a primary carer for the baby, and as such he was also a 'client' of the Midwife. A check within the hospital record system would have revealed that he may need a lot of support as a Father, and that Mother may not be able to rely on him as a stable and responsible carer for Child Q. In the same way as if this information had come from Mother herself, this should have triggered a risk assessment using the Thresholds and Pathways Guidance. An opportunity was therefore missed by Midwives to make further enquiries into the home environment, which would have perhaps included a discussion about who might look after Child Q whilst Mother was out.

5.1.17 The Hospital have confirmed that there is no policy or directive that prohibits the legitimate accessing of information, including the records of other care-givers, in cases where there are concerns regarding the welfare of the child. This healthy culture is in accordance with the reminder which was emphasised in the 2009 Laming report in which he pointed out that data protection laws rarely, if ever, prevent professionals from accessing information which could help safeguard children. *'Whilst the law rightly seeks to preserve individuals' privacy and confidentiality, it should not be used (and was never intended) as a barrier to appropriate information sharing between professionals. 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 a full blown 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.'* Since the Hospital fully agrees with the spirit of these comments by Lord Laming, and in fact does not prevent Midwives seeking appropriate information about Fathers, there simply needs to be a reinforcement of the existing policy amongst staff in order to dispel any uncertainty. **Recommendation 2**

5.1.18 Throughout her pregnancy Mother accessed Midwifery advice and care, however there were also occasions when she missed planned appointments such as:

- On the 3rd December 2013 she failed to attend a planned ante-natal appointment. The notes show that the Midwife tried to contact her by telephone but was unable to contact her. As a result a new appointment was sent through the post.
- On the 6th January 2014 she failed to attend for her 28 week appointment, the notes do not indicate what follow up happened, which is less than expected practice.

5.1.19 The Hospital IMR Author is of the view that the Midwifery Service should have shown more professional curiosity as to why Mother was missing routine appointments but attending self-referred contacts. The IMR Author referred to the hospital ante-natal care pathway (2012) which states: "*Women who do not attend appointments must be actively followed up (See guideline for 'Non-attenders to Antenatal Appointments')*".

5.1.20 On 5th February 2014 (when Mother was 33 weeks pregnant) Maternal Grandmother attended the Hospital A&E. She was brought in by Police as she was threatening to self-harm. On admission Maternal Grandmother demonstrated challenging behaviour by being abusive and aggressive to family and staff. The A&E assessment noted Maternal Grandmother was heavily dependent on alcohol with a history of depression. It is not suggested that information about Child Q's Grandmother should have been routinely accessed by Midwives, but had more professional curiosity been shown to the family as a whole, and questions asked about the proposed caring arrangements for Child Q, perhaps a risk assessment would have revealed her unsuitability to baby sit the baby and Mother might have been advised accordingly.

5.1.21 At 13:54 on 27th March 2014 Child Q was born. Mother had an uneventful labour Child Q's Father was present during the birth. A full physical assessment of Child Q was completed and no concerns were noted.

5.1.22 At 16.45 the same day Child Q and her Mother were assessed as ready for discharge and they were sent home. Child Q's notes state '*(Child Q) well, parents confident with care of baby.*'

## **5.2 Transition to Primary Care and Health Visiting**

5.2.1 This section of the analysis will consider the various visits to Child Q's home by first Midwives and then Health Visitors, and in particular analyse what they knew, or should have known, about the environment in which Child Q was living.

5.2.2 On 28th March 2014 a Midwife undertook the first post birth home visit. This was a routine visit and when interviewed for the current Review the Midwife was unable to remember any detail about it. Her notes indicated that there were no concerns raised. The Midwife was asked by the Hospital IMR Reviewer whether she could remember the presence of a dog in the property. She was very clear that she did not see a dog, hear a dog or smell the presence of a dog. The Midwife stated she is wary of dogs and so her usual practice if she is aware of a dog is to ask for the dog to be placed in another room away from her.

5.2.3 The Hospital IMR Reviewer asked the Midwife about her usual practice when she became aware of a family dog she stated she would talk about safety of the baby in relation to the dog. The Midwife also confirmed there is no standard procedure for discussing dogs but it is custom and practice of Midwives to give safety information if they are aware there is a dog in the family.

5.2.4 On the 5th day after the birth, a different Community Midwife made the first of 3 visits to Child Q. (Note: both these professionals were Community Midwives and it is not unusual for two different Midwives to see a Mother and child on the day of birth and the fifth day following birth). On the first visit she remembers Child Q's Father and Grandmother being in the home, but as with her colleague, when asked about the presence of a dog during her three visits, she stated at no visit did she recall a dog in the house. The Midwife also remembered whenever she attended the house the kitchen door was shut which may explain why no dogs were seen.

5.2.5 The Hospital IMR Reviewer explored this Midwife's usual practice regarding pet dogs and she stated that if dogs are present she discusses dog safety with the carer. She has been a Midwife for 15 years and when she provides parent-craft sessions she always mentions dogs at these sessions and how to maintain safety of an infant in the presence of a dog. This represents excellent practice. Unfortunately Mother did not attend parent-craft session during the ante-natal period and therefore would not have heard the safety discussion around dogs and infants.

5.2.6 It is noted by the Hospital IMR Author that the Midwives who visited the family home did not confirm with Mother who was actually living at home, and whether the Grandmother would play an active role in her care.



5.2.7 It is usual practice that a Midwifery Team will transfer the care of a baby and family to community Health Visitors at around the 10 day period. The Health Visiting Team at Child Q's GP surgery made initial telephone contact with Mother on 4th April 2014 to begin this process. It was only upon speaking to Mother on this occasion that the Primary Care Team discovered that the family had moved out of Northampton and were now living in a different town in the county. Perhaps because it was always her intention to return to Northampton, Mother did not register Child Q with a local GP surgery. A Health Visitor at the surgery contacted the local Health Visiting Team to arrange a transfer of health visiting services.

5.2.8 This disconnect between two key universal services allowed gaps in communication between the GP Practice and Health Visiting Service in the town the family had moved to. For example, Child Q received her first set of immunisations at the GP Surgery in June 2014. However, her Mother failed to attend for follow-up immunisation appointments four times in July, August and September 2014. There was no communication between the GP Surgery and the Health Visiting team within the practice, or to the Health Visiting team in the local town, to alert that Child Q was missing immunisation appointments. Although this is considered poor practice, in the context of the current Review it probably had no bearing on the outcome for Child Q.

5.2.9 There was no verbal handover between the Midwives and the Health Visitors. Delegates at the Practitioners Learning Event commented that this is not unusual, and that it is current practice that unless a Midwife has concerns she would not ensure there is a verbal handover to the Health Visitor. In this case, there was no verbal handover as there were no recognised concerns for Child Q or her family.

5.2.10 On 9th April 2014, a Health Visitor made the first visit to Child Q's home. This was known as the 'Primary Birth Visit' and the Health Visitor carried out a detailed assessment of Child Q using a hands-on approach, which involved handling, undressing and weighing Child Q naked. At the end of this visit the Health Visitor had no health concerns for Child Q, and during an interview with the Healthcare Foundation Trust IMR Reviewer she said that there she saw no evidence of any dogs in the household and she remembered the home environment as '*clean and welcoming*'.

5.2.11 Between that date and the end of July 2014, the local Health Visiting Team made 5 successful home visits to Child Q. This was 2 more visits than standard practice would normally require. At the Practitioners Learning Event it was explained that this was not because there were any particular concerns for the family but simply because there were concerns the Mother may be isolated as she had recently moved from Northampton to another local town and left all her friends behind. It is excellent that the Health Visiting Team provided this extra service, beyond that which was standard.

5.2.12 The Health Visitors had no knowledge of dogs living at the home until one of the team visited on 21st July 2014 to carry out Child Q's 4 month check-up. Even then, the Health Visitor did not physically see the dogs but she knocked on the front door and heard the sound of dogs barking inside. When Mother answered the door, the dogs had been put in the kitchen, behind a closed door. The Health Visitor recalled two names for the dogs being used.

5.2.13 The 21st July visit was the only occasion that any professional visiting the home became aware that there were dogs living with the family. During her interview with the Healthcare Foundation Trust IMR Reviewer, this Health Visitor described how she assumed that a family would naturally take safety precautions with a vulnerable baby. Although she documented the presence of 2 dogs she acknowledged that she did not explore with Mother the hazard that the dogs may pose towards any baby or young child. Neither did she enquire as to what sort of dogs they were nor, in particular, whether they were aggressive. As discussed in para 2.2.3 above, one of her health colleagues claimed that it is custom and practice for Midwives to give safety information if they are aware there is a dog in the family. This 'custom and practice' is clearly not applied by all Health Visitors and it is important that there is a measure of uniformity in the approach adopted by these two key health disciplines.

5.2.14 The issue of what, if any, training, Midwives and Health Visitors should have in respect of the dangers that some pets may present to children, was discussed at length both at the SCR Panel meetings and the Learning Event. It is important that these already busy professionals are not overburdened with yet more responsibility yet this case has clearly demonstrated that anyone meeting the dog which killed Child Q was likely to have been given the impression that it was aggressive and perhaps intimidating.

5.2.15 Many family homes have quite innocuous pets, but in cases such as this particular type of clearly aggressive animal it is reasonable to expect that had the visiting Midwives and Health Visitors known of its existence within the home they should have been curious as to whether it might be a hazard to the child in the same way that an unguarded open fire might be. It is a conclusion of this Review therefore that as part of the suite of information which Midwives and Health Visitors proactively seek from families about the home circumstances, the presence of pets within a household where babies and young children live should be included. Once the presence of a pet has been established, the professional will, as in the case of any other potential hazard, have to make a judgement about what, if any, risk the pet may pose. As stated at the beginning of this analysis section, this in no way implies an expectation that a health professional should be trained in the identification of banned types of dogs. This Review recognises that this is a role for trained specialists only and as mentioned previously, breed is not a reliable predictor of aggressive behaviour, but by treating a pet as 'just another potential hazard' it may at least trigger further enquiries. Certainly, had the dog been seen by the Health Visitor who heard him barking, it is reasonable to suggest that the Health Visitor would have initiated a discussion with the Mother about how safe the dog is with the child.

5.2.16 Without suggesting that Health Visitors need to be given extra training, it is reasonable to expect that once they have established the presence of a dog within a household containing babies or children a Health Visitor should proactively provide the parent or carer with some simple information material. There is a range of material about staying safe around dogs aimed for families and others who come into contact with dogs. For example, the RSPCA has a series of resources which help parents and children understand the different signals a dog may use to express his underlying emotional state as well as a set of rules to help keep children safe and dogs happy<sup>2</sup>. However, not all professionals appear to have access to dog safety material or are aware that such material is available which in turn influences whether or not it is provided to parents both ante and postnatal.

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<sup>2</sup> <http://www.rspca.org.uk/adviceandwelfare/pets/dogs/company/children/safe>

5.2.17 A recent Review conducted by Public Health Wales<sup>3</sup> concluded that the most important piece of advice for members of the public is *'to never leave a baby or young child unsupervised with a dog, even for a moment, no matter how well you know that dog'*. It also made the recommendation that this should be included in information for parents, the parent held personal child health record and other routes relating to public information on home and family safety. The NSCB should explore whether it is feasible as a matter of routine for Midwives and Health Visitors to proactively ask whether there are pets in the household, and if so to provide the leaflets and information highlighted above. **Recommendations 3 and 4**

5.2.18 A few weeks before the 21st July visit by the Health Visitor, Child Q's Father was sent to prison but Health Visitors were unaware of this. In fact, when they visited the house they were led to believe by Child Q's Mother that he was simply out at work. It is of note that although it is believed he lived in the house until June 2014 he was never seen by any Health Visitor at the home, and when his name came up Mother claimed that he was a builder or roofer who worked long hours. This deceit by Mother may well have had an impact on whether the Health Visitors enquired as to whether she had sufficient support within the household. Whilst the Health Visitors had a record of Child Q's Father's name, and the fact that he lived at the address, there is no record of his history, capabilities as a parent, or the support he provided for Child Q and in fact, from May to October when she died, it is now known that he wasn't in the household at all, which left Mother as a young, first time, single parent of a baby.

5.2.19 Whilst accepting that Mother engaged in a pattern of deceit, it is still reasonable to expect that as part of the 'Think Family' agenda more professional curiosity should have been demonstrated to explore, and document information, about Child Q's Father. Health Visitors should have attempted to find out whether he was a young parent too, whether there were any social or medical concerns about him, and whether there were any concerns that he may pose a risk to Child Q. This pattern of being less than curious about men in the household is an extension of the issues described above during the period around Child Q's birth.

5.2.20 However, as already noted, there is clear evidence that Child Q's Mother was engaged in a strategy of deceiving professionals who were attempting to work with her in a trusting partnership, and the implications of this were explored during the current Review.

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<sup>3</sup>[http://www.wales.nhs.uk/sitesplus/documents/888/20140811\\_CDR\\_RapidReview\\_DogBites\\_CH\\_v1\\_Final.pdf](http://www.wales.nhs.uk/sitesplus/documents/888/20140811_CDR_RapidReview_DogBites_CH_v1_Final.pdf)

5.2.21 There is a great deal of literature on the subject of resistant parents in a safeguarding context, for example, it is identified that deception is '*a significant feature of everyday child protection practice*' (Tuck, 2013, p.5) and in their relations with professionals, parents were sometimes found to be '*intentionally deceptive or manipulative*' (Lord Laming, 2009: 51) and capable of going to '*great lengths to hide their activities from those concerned for the wellbeing of a child...*' (Lord Laming, 2003:3). Reder et al. (1993) discuss how calculating and convincing parental conduct of doing just enough to keep workers at bay impairs their professional judgments, a behaviour known as disguised compliance (Reder et al., 1993) Both deceitful behaviour and disguised compliance are evident in '*assessment savvy*' (p.65) parents, willing to adopt their behaviour to come across as compliant when needed (Brandon, et al. 2008)

5.2.22 Any experienced safeguarding professional, such as a Social Worker or Police Officer, should be aware that sometimes parents and carers may be less than truthful about their willingness to work with them, but in respect of universal service providers such as Health Visitors there is an expectation that they should be able to do their job within in an atmosphere and relationship of trust and support. Therefore they may be more susceptible to a parent who takes advantage of this trust in order to deceive.

5.2.23 Mother seems to have created an illusion when engaging with health visiting staff. She was described in very positive terms in health visiting notes with descriptions such as '*very petite and always beautifully made up*', yet there are several examples of deceit by Child Q's Mother in this case. These include not telling Health Visitor's that the child's Father was in prison, but rather deceiving them by saying he was a builder/roofer working long hours; using different surnames; and failing to bring Child Q for her immunisations and giving different reasons to different practitioners for this.

5.2.24 In hindsight this '*disguised compliance*' was critical as at the time there were no identifying factors for practitioners, but had they known, for example, that she had lied to conceal the fact that her partner was in prison, this would have put a different complexion on a person the health professionals considered as '*perfect*', and they may have taken more steps to discover exactly what parenting care and support was actually present for Child Q and her Mother.

### **5.3 Domestic abuse incident April 2014**

5.3.1 When Child Q was 4 weeks old Police were called to attend a violent domestic incident at her house. The significance of this event is that Maternal Grandmother was the protagonist, she was drunk, and Child Q was present, so this was potentially an opportunity for agencies to assess the arrangements within the home and find out more about who was caring for Child Q.

5.3.2 The incident occurred on 21st April 2014 and it was reported by the Police Officers attending that Maternal Grandmother was behaving aggressively towards Mother, allegedly assaulted her. One of the officers expressed concern that Maternal Grandmother, who was intoxicated, was near Child Q and that Child Q could get hurt as a result of Maternal Grandmother's behaviour. However, Mother did not want the Officers to take any specific action against Maternal Grandmother other than removing her from the situation, which the officers duly did.

5.3.3 The Officers completed a DASH form (domestic abuse risk identification checklist) and made a referral to the Police Child Protection Team in respect of Child Q. Mother gave the Police an alias. The referral was dealt with by a civilian member of staff from the Police, who checked the Police database against the alias and found nothing. The civilian member of staff decided to take no further action over this referral. The name given was not checked as being a possible alias and Maternal Grandmother was not checked. Either check, had it been correctly carried out, would have revealed a substantial history of involvement with the Police in relation to alcohol related incidents and domestic abuse incidents involving Maternal Grandmother and Mother.

5.3.4 In this instance, the child protection team staff member failed to properly interrogate the information systems, and when trying to ascertain *why* the correct level of checks were not conducted, the staff member told the Police IMR Reviewer that they had joined the Child Protection referral team 4 months before the incident and had only received basic training from the Detective Sergeant in respect of the use of the force intelligence system. The training provided should have equipped the staff member to conduct a suitably thorough search, however when interviewed by the Police IMR Author, the staff member claimed they were simply unaware how to cross reference and search for real names and possible aliases on the Police intelligence system.

5.3.5 Although no further action was taken, it is useful to analyse how Children's Social Care might have responded to a referral from the Police in relation to this incident. Had a referral come through as a result of appropriate checks by the Police against Mother and Maternal Grandmother, it would have gone into the Multi-Agency Safeguarding Hub triage process, detailing that Maternal Grandmother, a person with a history of alcohol misuse, was alleged to have assaulted Mother in the presence of Child Q. Children's Social Care would have had access to the history of involvement with Maternal Grandmother, Mother and the family and this would have informed the decision about any response.

5.3.6 However, in order to hypothetically explore this issue further, the description of the incident was sent to a Service Manager within Northamptonshire Children Families and Education. She expressed the view that on the basis of the information about the incident and acknowledging the background information available to Children's Social Care staff on the database, it is likely that no further action would have been taken. The Service Manager stated that this referral would have been dealt with by the Multi-Agency Safeguarding Hub triage process and would not have met the threshold for a Multi-Agency Safeguarding Hub enquiry. The Service Manager suggested that in response to the referral a letter would have been sent to Mother advising her that the referral had been received and that the letter may also have included advice and information about where Mother could access support if she wished to do so.

## **5.4 The two complaints about the dog**

5.4.1 Although the two incidents to be analysed in this section were not related, they were two potential opportunities for professionals to recognise that an aggressive dog lived in the home where Child Q resided.

5.4.2 In fact the first incident took place in January 2014 when Mother was 6 months pregnant with Child Q. A woman (who was almost certainly Mother, although she only provided her surname and an address) took her dog to a veterinary practice in Northampton. The Vet who treated the dog was very concerned about the aggressive temperament of the dog, and was also concerned that the dog may be of a banned type, subject to Section 1, Dangerous Dogs Act 1991. The dog was extremely aggressive and the Vet was unable to treat the dog without full sedation as it was considered the dog may well bite and cause injury.

5.4.3 The Vet contacted the RSPCA for advice and the RSPCA Inspector noted the details and then contacted the Police to log and refer this concern with them. It should be noted that the RSPCA is an animal welfare charity and its officers are not permitted or trained to 'identify' any suspected banned type. The RSPCA Inspector was not given any information by the Vet as to the possibility of the owner either being pregnant or having children at home and there is equally no reason to suppose that the Vet even realised that the dog owner was pregnant. Having thoroughly examined their role, this Review does not offer, or imply, any criticism of the action taken by the RSPCA or the veterinary practice although it should be explored whether it is feasible or desirable for Vets to make a direct referral to the Police in such cases.

#### **Recommendation 5**

5.4.4 The Police on the other hand, have a statutory duty under Section 11 Children Act 2004 to make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children. Although there is no doubt that the Police received the information from the RSPCA, it was not acted upon either by way of a home visit, or by considering whether children may be present in the same household as the aggressive dog. It is not within the scope of this current Review to investigate why the Police failed to action the intelligence but suffice to say this incident was referred to the Independent Police Complaints Commission (IPCC) on the 10<sup>th</sup> October 2014. A subsequent IPCC investigation has taken place and this Review is informed by the IPCC Report into that investigation. It was the view of the IPCC Investigator that one Police Constable had a case to answer for misconduct, because the Police Officer "*should have done more to action the intelligence*". The IPCC Investigator does not specify exactly what action he thinks should have been taken by the Police, but the potential options would have been for an officer to visit the home and seek to inspect the dog, or else apply to the Magistrates Court for a warrant to enter the house, take possession of the dog and assess it. In the latter case, the Magistrates could potentially have ordered the dog to be destroyed or else allowed the owner to keep it under strict conditions. The Police Officer concerned was dealt with by way of the lowest level of sanction, 'management advice', and it was noted by the Force that the Police Officer "*had acknowledged their conduct fell below the standards expected and has demonstrated a commitment to improve their conduct in the future. It goes without saying that given the tragic circumstances leading to this investigation (the individual) has learnt from this.*"



5.4.5 It is noted the Police had no policy in place at the time of this event to deal with dangerous dogs, however, a guidance document is now in place across the four East Midlands forces. In addition the Police has now also recruited a full time Dog Legislation Officer. Every Police Officer has received an email with a link to the guide, for self-learning. A self-learning PowerPoint presentation has been prepared for all officers and is now available throughout the East Midlands policing region. This has also been passed onto partner agencies, although the Police acknowledge that they are unaware of the onward distribution arrangements. The NSCB should carry out an audit to see if relevant staff from the constituent agencies, particular in the Health Service, have access to, or knowledge of, this learning tool. The NSCB should also ensure that constituent agencies are aware that the Police Dog Legislation Officer will, on request, provide suitable training for any of the Police partner agencies. **Recommendation 6**

5.4.6 All Police Officers receive basic child safeguarding training and the potential risk that aggressive dogs may pose to children within a household should be specifically included within such training. The NSCB should audit what the Police are doing to improve training for front line patrol officers in respect of the potential hazard that an aggressive dog may pose to children resident within a household. **Recommendation 7**

5.4.7 It is also recommended that the Independent Chair of the NSCB writes to the Chief Executive of the College of Policing, drawing his attention to the findings of this SCR, with a view that in future the issue of aggressive dogs, in the context of child safeguarding, can be included within the national policing safeguarding training curriculum. **Recommendation 8**

5.4.8 Although Child Q had not been born at that time, if the dog taken to the Vet was, as seems likely, the same dog which later killed her, it goes without saying that had the Police taken action over the intelligence from the RSPCA they may have been in a position to obtain a magistrates warrant to remove the dog from the house for an assessment. This must be considered as potentially a missed opportunity to change the outcome for Child Q.

5.4.9 The second occasion when professionals may have had the opportunity to make further enquiries into the presence of an aggressive dog in the household came on 9th May 2014 when the local District Council received a complaint from a neighbouring property alleging noise nuisance from barking dogs living in Child Q's home.

5.4.10 During the investigation an officer from the local Dog Warden Service spoke on the telephone to Mother (who used a false name). Mother identified herself as the householder and the owner of one of the dogs. She advised the Dog Warden that in addition to her dog, which she described as 'Staffie' type, she also looked after her brother's dog for two days a week. She described this dog as a Bull Mastiff.

5.4.11 It is noted that the local District Council receives 292 dog related cases each year, including 100 relating to barking dogs. It is not practical therefore for each of these complaints to trigger a visit to the owner of the dog being complained about and the Dog Warden did not visit Child Q's home. The usual practice is to send a warning letter and then ask the complainant to monitor the situation and in the case of Mother's dogs, a letter appeared to have resolved the complaint because a follow up enquiry with the complainant revealed that the dogs were no longer a nuisance and so the case was closed.

5.4.12 During the telephone conversation with the Dog Warden, Mother did say she *'did not leave the dogs barking because this would disturb her baby.'* The fact that it was now apparent that a child lived in the household would not necessarily trigger any further action unless the complaint which initiated the contact had indicated that the dogs were dangerous or aggressive. In this case the complainant was concerned about the noise, but did not indicate any level of dog aggression. That being the case, it seems entirely reasonable that the Dog Warden did not consider any safeguarding concerns for Child Q.

## **5.5 The response to the attack and admission to A&E**

5.5.1 During the evening of Friday 3rd October 2014, Mother went out for a social evening and left Child Q in the care of her Grandmother. The two dogs were also in the house.

5.5.2 At about 22:30 hours a 999 call was received by Police, from Maternal Grandmother during which the first words recorded were, *"He has killed my granddaughter"*. It was established that Maternal Grandmother was referring to the dog, and that the attack on Child Q was still taking place. The incident was graded by Police as an emergency and local response officers were dispatched, as were armed officers. The Police also made an immediate referral to the regional ambulance control room who gave an ETA for their responders as being 17 minutes.

5.5.3 The first officers arrived at the scene within five minutes, the dog was in the lounge. The front door was locked so the officers forced the door and went into the lounge from where they could hear screaming. The dog went towards the officers barking but they managed to back the dog into the kitchen by spraying it with intermittent bursts of PAVA (an incapacitant with similar properties to CS gas). A Police officer had to hold onto the door handle to prevent the dog getting back into the lounge.

5.5.4 For the purposes of this Review there is no need to go into much more detail about the scene which faced the Police Officers when they arrived at Child Q's house. As described at the beginning of this Overview Report, the two officers who initially attended displayed immense courage in stopping the attack on Child Q and her Grandmother by the dog. All the medical evidence suggests that Child Q would have already died from her horrific injuries before the Police even arrived at the house so although the officers, and later paramedics, made attempts to resuscitate her, these attempts had no chance of success.

5.5.5 Although it had no bearing on the outcome for Child Q, it is important that this Overview Report makes comment about a discrepancy between the recordings of the police and ambulance timings.

5.5.6 The initial request for an ambulance had been made by the Police at 22:31 hours when the incident was first reported. The call was coded by the regional ambulance service as a Red1 requiring an 8 minute response and the closest possible resource was dispatched. At 22:46, the Police Officers were attempting to resuscitate Child Q and asked for an estimated time of arrival for the ambulance professionals and the ambulance control room confirmed that they had logged the crew as being on scene. At 22:50 Ambulance staff were on scene and the first recorded treatment of Child Q took place. The absolute reason for the delay cannot be determined however there is no evidence that there was fault in the regional ambulance service's tracking system for vehicles which logs the ambulance as being on scene automatically once the ambulance triggers the 200m threshold.

5.5.7 It has been acknowledged by the regional ambulance service that they were unable to provide a resource within the 8 minute target however all avenues and attempts to get medical help to the scene quicker were exhausted. The early identification of this incident meant that a doctor was dispatched to scene in an attempt to ensure all pre hospital care would have been available.

5.5.8 The only other issue which needs to be covered in relation to the deployment of professionals to this scene is that the Police Dog Legislation Officer was actually on duty when this incident was reported. He had a great deal of expertise, and of course specialist equipment, which could have assisted with containing the dogs, affording some protection to the officers. However he was not contacted during the incident, and had no knowledge that it was taking place. This was an unfortunate oversight by the Police which, although it had no bearing on the outcome for Child Q, could have detrimentally affected the other Police Officers and Ambulance staff at the house.

5.5.9 A Doctor working with the regional ambulance service also attended the scene and at 23:08 hours he declared that Child Q was dead and instructed that resuscitation should cease. The ambulance crew transferred Child Q to Hospital with a pre alert to their ED department as per the child death process.

5.5.10 A referral to children's social care was completed for Child Q in accordance with the child death process in the regional ambulance service. On the safeguarding referral to children's social care it identified that the Grandmother was believed by paramedics to be intoxicated.

## **6. Conclusions and Summary of what has been learnt**

6.01 The circumstances of Child Q's death placed a statutory requirement on Northamptonshire Safeguarding Children Board to carry out a Serious Case Review in accordance with Government Guidance *Working Together to Safeguard Children (2013)*. The Review should have been completed within 7 months of the death of the child but it was subject to lengthy delays because of requests made by the criminal justice agencies to alter the timetable. In the end, no convincing reason is evident as to why the delay was necessary and in future any request for a delay to a Serious Case Review should be subject to greater critical scrutiny.

6.02 Child Q died because she was attacked by a dog which was one of two brought into the family home by her Mother. The dog was so fierce that a Vet had earlier refused to examine it for an illness unless it was first fully sedated. Child Q's Mother was fully aware that her own Mother had alcohol related problems yet she went out for the evening leaving her in sole charge of the baby while the dogs were in the house. The considered view of the Crown Prosecution Service is that Child Q's Mother and Grandmother were jointly responsible for failing to prevent the attack which killed Child Q.

6.03 Child Q had never been flagged up by any professional or agency as being at risk of harm and she was not known to Children's Social Care. Child Q was a 'visible' child in the sense that she received appropriate care and services in the Maternity Unit at the Hospital, and thereafter, until the day before her admission to A&E, she was seen regularly by Midwives and Health Visitors. No-one ever expressed any concerns for her wellbeing, in fact she was believed by health staff to be a very happy child. The service provided by Health Visitors was above and beyond that required by their standard practice requirements.

6.04 Although universal healthcare services were provided to the family, little was known by Midwives and Health Visitors about her Father. It was assumed that he lived in the house and was helping to care for the child, when in fact, for several months before she died, Child Q's Father was in prison.

6.05 There is evidence that Child Q's Mother was sometimes deceitful in her dealings with health professionals, particularly concerning the whereabouts of the Father, which may have contributed to them having an overly positive view of life within the home. This 'disguised compliance' was critical as at the time there were no identifying factors that Child Q could be a vulnerable child. Had health professionals known that her Mother had lied to conceal the fact that her partner was in prison, this would have put a different complexion on a person the health professionals considered as 'perfect', and they may have taken more steps to discover exactly what parenting care and support was actually present for Child Q and her Mother.

6.06 This Review has concluded that more should have been done to ascertain the role that Child Q's Father may play in her life. It is accepted that sometimes a Mother may give birth to a child and either declare themselves to be a single parent, or refuse to reveal who the Father is. However, Child Q's Father was visible at the ante natal appointments, and at the birth, so there should have been no doubt that he was going to be a primary carer for the baby, and as such he should also have been considered as a 'client' of the Midwife. A simple check within the hospital record system would have revealed that because of his own alcohol related problems, he may have needed a lot of support as a Father, and that Mother may not be able to rely on him as a stable and responsible carer for Child Q. There was little professional curiosity evident in respect of the health professional's dealings with the Father and no checks were made, even within the internal hospital records, about his background. Health professionals expressed a perception that they are not allowed routinely to check a Father's records, but this perception is wrong, and needs to be corrected.

6.07 On the one occasion when a Health Visitor became aware that there were dogs within Child Q's household, no curiosity was shown as to whether they could be a risk to her. This in no way implies an expectation that a health professional should be trained in the identification of banned types of dog, but by treating a pet as 'just another potential hazard' it may at least trigger further enquiries. Certainly, had the dog been seen by the Health Visitor who heard him barking, it is reasonable to suggest that the Health Visitor would have initiated a discussion with the Mother about how safe the dog is with the child.

6.08 Without suggesting that Midwives or Health Visitors need to be given extra training, it is reasonable to expect that once they have established the presence of a dog within a household containing babies or children a Health Visitor should proactively provide the parent or carer with some simple information material. There is a range of material about staying safe around dogs aimed for families and others who come into contact with dogs.

6.09 Three months before Child Q was born, the RSPCA alerted the Police to the fact that an aggressive dog had been taken to a local Vet (this was undoubtedly the dog which killed later Child Q). The Police failed to carry out any further enquiries into that dog, or into who lived in the same household as the dog. The Police have a statutory responsibility to make arrangements for ensuring that their functions are discharged having regard to the need to safeguard and promote the welfare of children and any call about an aggressive, or banned type of dog should be considered with that duty in mind. Had the Police visited Mother at that time, they would possibly have realised that she was pregnant and shortly to have a baby living within the house.

6.10 Although this Review has identified some opportunities whereby further enquiries could have been made into the home circumstances, even if the full home situation had been known, realistically, the most that would have happened is that Mother would have been given advice, and perhaps a leaflet, warning her that dogs can be dangerous around children.

6.11 Even if Mother had been given that advice about dogs and children it is doubtful if it would have affected the outcome for Child Q. This is because this Review has concluded that Mother was already aware how aggressive her dog was, and there is every likelihood that she normally kept the dog well away from Child Q. Unfortunately on the night in question, the dog appears to have escaped from its cage due to a faulty lock on the door and managed to attack the child.

6.12 Although some poor practice has been highlighted in this Overview Report, nothing has been revealed by this Review which suggests that any single professional could, or should, have prevented Child Q's death.

## **7. Recommendations for Northamptonshire SCB**

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

***The recommendations are not listed in an order of hierarchical importance, but are in line with how they fall within the report. All agencies are to review their practice against the recommendations within the report.***

### **Recommendation 1**

The NSCB should conduct a detailed discussion which leads to a coherent strategy and policy dealing with a request from any agency to delay or disrupt the timescales of any future Serious Case Review. The policy should require compelling reasons to be given in writing and the Independent Chair of the NSCB to make the final decision. (2.8.10)

### **Recommendation 2**

The NSCB Chair should write to the Hospital Executive Director for Safeguarding to seek assurance regarding the mechanisms and processes for accessing information where there are legitimate concerns regarding relevant care-givers, requesting reassurance that the Fathers in potentially vulnerable families will be subject to the same level of enquiry as Mothers. (5.1.17)

### **Recommendation 3**

The NSCB should promote the good practice whereby, as a matter of routine, Midwives and Health Visitors proactively ask parents whether there are pets in the households they visit. To facilitate this standardised, up to date, and evidence based information on keeping safe around dogs, should be made available and delivered by such health professionals, in line with current RSPCA guidance for front line practitioners in universal services. (5.2.17)

### **Recommendation 4**

The NSCB Chair should write to the Chief Executive of the Perinatal Institute for Maternal and Child Health and draw their attention to the findings of this Review with a view to encouraging the Institute to seek amendments to relevant midwifery standard forms to include specific questions to parents regarding dogs/pets. (5.2.17)



### **Recommendation 5**

The Independent Chair of the NSCB should write to the Chief Executive of Royal College of Veterinary Surgeons drawing his attention to the findings of this SCR with a view that they can consider whether, in respect of dangerous or aggressive dogs, it is feasible or desirable to create a mandatory reporting scheme to statutory authorities for their members. (5.4.3)

### **Recommendation 6**

The NSCB should ensure that constituent agencies are aware that the Police Dog Legislation Officer will, on request, provide suitable training for any of the Police partner agencies. (5.4.5)

### **Recommendation 7**

The NSCB should seek reassurance from Police that in light of their statutory duty under Section 11 Children Act 2004 safeguarding training for front line patrol officers recognises aggressive dogs as a potential hazard to children within the home, and that appropriate referrals will be made to the Multi Agency Safeguarding Hub if Police are aware of an aggressive dog in a household where a child is ordinarily resident. (5.4.6)

### **Recommendation 8**

The Independent Chair of the NSCB should write to the Chief Executive of the College of Policing, drawing his attention to the findings of this SCR with a view that in future the issue of dog safety in the context of child safeguarding can be included within the national policing safeguarding training curriculum and Authorised Professional Practice (APP) Guidance. (5.4.7)

## References

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## Appendix A

### Terms of Reference

#### Serious Case Review

#### Child Q

**DOB: 27.03.2014, DOD: 03.10.2014**

##### SCOPE & TERMS OF REFERENCE

The Serious Case Review Panel took the decision that, with reference to the requirements as set out in Chapter 4 of *Working Together to Safeguard Children* (2013) that the threshold was met to commission a Serious Case Review in respect of Child Q.

The purpose of the Review is to identify improvements which are needed and to consolidate good practice. LSCBs and their partner organisations will need to translate the findings from Reviews into programmes of action which lead to sustainable improvements and the prevention of death, serious injury or harm to children.

The following **principles** should be applied by the LSCB and its partner organisations to all Reviews:

- There should be a culture of continuous **learning and improvement** across the organisations that work together to safeguard and promote the welfare of children, identifying opportunities to draw on what works and promote good practice;
- The approach taken to Reviews should be **proportionate** according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are **independent** of the case under Review and of the organisations whose actions are being Reviewed;
- Professionals should be involved fully in Reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Families, including surviving children, should be invited to contribute to Reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively. This is important for ensuring the child is at the centre of the process<sup>4</sup>. Engagement with the family will be managed by the NSCB.
- Final reports of SCRs **must be published**, including the LSCB's response to the Review findings, in order to achieve **transparency**. The impact of SCRs and other Reviews on improving services to children and families and on reducing the

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<sup>4</sup> British Association for the Study and Prevention of Child Abuse and Neglect in Family involvement in case reviews, BASPCAN, [further information on involving families in reviews](#).

- incidence of deaths or serious harm to children must be described in LSCB annual reports and will inform inspections; and
- Improvement must be sustained through regular monitoring and follow up so that the findings from these Reviews make a real impact on improving outcomes for children.

SCRs and other case Reviews should be **conducted** in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed; and
- Makes use of relevant research and case evidence to inform the findings.

The methodology agreed for this Review is a blend of traditional and new: with agencies involved with the family required to complete Internal Management Reviews that should be clearly focussed on addressing the issues for consideration outlined below. There will also, and in parallel, be a process of greater collaboration through conducting conversations with the practitioners and clinicians involved, and holding a multi-agency briefing at the start and near the end of the process, in order to identify learning and encourage reflection on their involvement; to examine the actions and decisions taken; and to understand the context.

**Issues for consideration by IMR Authors and the Lead Reviewer** (when conducting conversations and writing their reports) falls into two main strands:

#### **Capacity of carers to safeguard the child**

- What did professionals know about the Mother and Maternal Grandmother and their likely capacity to be able to safeguard the baby from any hazard within the home, and what did professionals do with this information?

#### **What was known about the dog**

- What did / didn't agencies do to safeguard the child knowing a dog was in the property and was subsequently identified to be a dangerous dog.

**The time period for this Review is 1 October 2013 to 3 October 2014 (date of child's death)**

Agencies should include a summary of any earlier contact with the family relevant to the learning aims of this Review.

Agencies should consider this case in the light of other recent Reviews

- Case Mapping Exercise; child who sustained a dog bite and had to have the lower part of her leg amputated due to the severity of the injury and a child who sustained a bite to the face that required over 30 stitches.

Internal Management Reviews should concentrate on addressing the core issues identified above. This is in line with the greater discretion in methodology and concentration on learning and improvement as set out in *Working Together 2013*.

**IMR reports are required from the following agencies:**

- Police
- RSPCA
- GP
- Healthcare Foundation trust; Health visiting
- General Hospital; Midwifery

**Statements of Information are required from the following agencies:**

- Children's Social Care
- Regional Ambulance Service
- A&E, General Hospital
- Environmental Health, local District Council
- Housing, local District Council
- Housing, local Borough Council
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**A template for the IMR and Statements of Information reports will be provided.**