# Serious Case Review Child Q
# 6 Step Briefing

### The Background

Child Q was a 7 month old baby who sadly died following an attack by the family dog in the family home.

### Safeguarding Concerns

In the time leading up to Child Q's death, professionals had no evidenced / apparent safeguarding concerns. Since the incident and through this review it has become clear that Mother was not being truthful with professionals and, had she been, professionals may have taken a more curious role in considering the family.

### The Incident

On the evening of the incident, Child Q was in the care of her Maternal Grandmother as mother had gone out for the evening. One of the two dogs within the household managed to force its way out of its cage in the kitchen and through the kitchen door. It proceeded to the lounge where Child Q was in her Moses basket. The dog savagely attacked the baby who sustained catastrophic injuries, from which, according to medical professionals and the pathologist, she had no chance of survival.

### The Review

The Serious Case Review (SCR) considered the period from the mother's pregnancy to Child Q's death. All agencies contributed to the review. A colleague from the RSPCA and a Dog Legislation Officer from the regional police team sat on the SCR Panel, which provided valuable input and support to the review and Panel members.

The Overview Author and SCR Panel Members would like to recognise the bravery of the two Police Officers who first attended the scene and managed to contain the dog in very difficult circumstances that threatened their own safety.

### The Findings

* There is evidence that Child Q's Mother was sometimes deceitful in her dealings with health professionals, particularly concerning the whereabouts of baby's Father, which may have contributed to them having an overly positive view of life within the home.

* This Review has concluded that more should have been done to ascertain the role that Child Q's Father may play in her life.

* On the one occasion when a Health Visitor became aware that there were dogs within Child Q's household, no curiosity was shown about whether they could be a risk to her.

* 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 children's workforce professional should proactively provide the parent or carer with some simple information in relation to safety.

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**The Findings cont'd.**

* Even if Mother had been given that advice about dogs and children, it has been assessed to be doubtful if this would have affected the outcome for Child Q.

* 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.

**Recommendations**

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. The NSCB Chair should write to the Northampton General 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.

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 frontline practitioners in universal services.

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. 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.

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.

7. The NSCB should seek reassurance from Northamptonshire 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.

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.

# Good Practice and Evidence as a result of this Audit and similar Reviews

There is a comprehensive Dog Policy & Procedure, along with an assessment tool and RSPCA guidance, on the NSCB website. Please click here for further information.

The Police Dog Legislation Officer at Northamptonshire Police will, on request, provide training to any of the Northamptonshire Police partner agencies.

The findings from this Review link with a previous Case Mapping Exercise which reviewed two separate incidents of serious dog bites within this county. As a response to the Case Mapping Exercise findings and this Review, A&E professionals are required to refer to the MASH, any child injury they treat which is sustained as a result of a dog bite. This ensures professionals are considering the incident holistically and whether any other children may be at risk.

The RSPCA has a wealth of information available on their website about dogs, cats and other pets and their health and how to manage their behaviours etc. Click here to access their website.