Serious Case Review Briefing

Bristol Safeguarding Children Board **January 2018**

Overview

In January 2018 the Bristol Safeguarding Children Board published a Serious Case Review concerning the death of Aya, a six month old baby. The review found that there were no missed indicators by professionals, and that her death could not have been prevented given what was known. However there were other areas of learning from the case that are detailed in this briefing. The full review can be downloaded from the BSCB's website.

When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the Local Safeguarding Children Board should always conduct a serious case review.

It is the expectation of the BSCB that all professionals in Bristol know the findings of Serious Case Reviews in order that they can make changes to their practice to safeguard children in

Relevant Policies

Injuries in non-mobile babies

Child Protection and Domestic Abuse

Children of parents who misuse substances

Responding to Abuse and Neglect

Relevant Resources

Bristol Mental Health Services

Bristol Children's Centres

Post-natal support for fathers

BSCB Training

The BSCB run a wide range of inter-agency training which is available to all professionals working in Bristol.

Details of our training program and course booking can be found at https://bristolsafeguarding.org/children-home/training/

Aya

Aya was born in June 2016. Her mother and father were not in a relationship, but decided to live together so they could both parent Aya. Aya was the only child in the family. She was a happy healthy child and developed well after some initial feeding difficulties.

During the pregnancy there were her mother and father both shared with midwives that they both were sometimes feeling low in mood. Her father told midwives that he occasionally used cannabis. Appropriate additional support was signposted to and advice given, but the pregnancy was considered low risk and Aya was born without complications. Aya's parents moved to Bristol during the pregnancy and had limited support locally. Aya's mother was encouraged to engage with the local Children's Centre after Aya's birth to address her social isolation. She and Aya enjoyed attending groups and made friends. Apart from universal health care and health visiting, the children's centre was the only additional service involved with Aya prior to her death.

Through the review we found out that Aya's father had used cannabis, cocaine and other drugs since his older adolescence. He described using increasing levels of drugs following his parents' deaths. Her father also described having experienced low mood and poor mental health for many years linked to these bereavements. He and her mother both reported that his drug use reduced significantly after Aya's was born. The full information was not known to professionals as Aya's father never sought professional support around these issues. After Aya's birth her father did not attend any health visiting appointment because he was at work.

On December 24th 2016 Aya was being looked after by her father while her mother was out. He called 999 in the early hours of December 25th stating that Aya was unresponsive. Paramedics and doctors attended, however Aya was tragically pronounced dead at the scene. Aya died as a result of non-accidental injuries. Her Father pled guilty to her murder and received a life sentence in July 2017.

To date, Aya's father has not been able to provide an explanation as to what triggered his violence towards Aya that night. He had regularly cared for her on his own previously and her mother had had no concerns.

Routine Domestic Abuse Questioning

The review found that Aya's mother was never asked about domestic abuse in her meetings with midwives and health visitors. This meant that Aya's mother never explored the dynamics in her relationship with Aya's father. She told the review she thinks she would have recognized some signs of financial control as she was lending him large sums of money.

You should:

- Whenever possible, see both parents separately to encourage engagement with services, and also to ask questions related to domestic abuse of both.
- Remember past learning in relation to domestic abuse – it is not a tick box, ask repeatedly, at different times during the professional relationship, never assume that it doesn't apply to a family.

Things to Consider

Think Fathers

The Serious Case Review found that professionals did not always include Aya's father as much as they could have. Appointments were not made at times he could attend and he was not provided with the same information as Aya's mother. Commissioners and providers of services need to consider whether they offer a service that is accessible as possible to both family members and which promotes fathers involvements. Professionals such as health visitors and family support workers should always make every possible attempt to engage fathers. This may include having specific telephone contact with them or arranging meetings at times which they are able to attend in person. Father's needs and social histories should form an equal part to any family assessment as that of the mother. Aya's father acknowledged that he 'buried my head' about the impact of his drug use and mental health difficulties. While not guaranteed, a proactive approach may have provided opportunities for her father to recognise and acknowledge these difficulties to enable professionals to provide appropriate support.

Holistic Assessments

There was good practice identified in the review from all the services who worked with Aya and her family. The GP, midwife and health visitor all explored the impact of her parents' unconventional living situation with Aya's mother and supported her to access services through the Children's Centre which she valued. The review found that not all assessments were fully completed or written up. This limited the ability of services to explore and assess Aya's father's needs with him. The NSPCC provide a factsheet on undertaking good quality assessments which can be found here.

Injuries in non-mobile babies

The Serious Case Review identified that the Injuries in non-mobile babies policy was not followed in one incident where a health professional observed a very small circular bruise on Aya's neck. This was thought to have been caused by Aya rubbing on baby-grow popper. Had the policy been followed it is unlikely that it would have initiated any further involvement however it highlighted the need for the policy to be followed in all cases.

Tell the BSCB how you have used this briefing to improve practice at:

- Email: bscb@bristol.gov.uk
- Twitter: @BristolLSCB
- Website: www.bristolsafeguarding/children/contact/contact-the-bscb