Devon Local Safeguarding Children Board

LSCB SCR CN02

<u>OVERVIEW REPORT</u>

Report undertaken in accordance with Chapter 8 of the Department of Health Guidance "Working together to Safeguard Children"

Regarding **Subject**

Born: 2002

Completed by: Mrs H Hyland on behalf of the Devon Local Safeguarding Children's Board

Report Dated December 2007

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1. Introduction

1.1 On the 9th August 2006 Subject's mother, BM, contacted the police stating that she had harmed Subject by stabbing her. Subject was admitted to the North Devon District Hospital where it was confirmed that a total of 32 cuts or puncture wounds had been inflicted upon Subject, although none of them was found to be life threatening. Subject also had bruising of recent origin around the left knee and left elbow and forearm that were thought to be consistent with her having being restrained. Subject was also heavily infested with nits and lice.

1.2 Subject's mother, BM, previously being diagnosed as suffering from a mental illness, had expressed feelings that she might harm Subject on more than one occasion. Following the incident on the 9th August 2006 BM was arrested on suspicion of attempted murder but following further psychiatric assessment was detained under Section 2 of the Mental Health Act and placed in a secure psychiatric setting.

1.3 Subject has made a good physical recovery from the injuries that she sustained on the 9th August although she has been left with significant emotional and psychological difficulties. She has returned to the care of her father, Mr BF.

2. Terms of Reference

The Devon Local Safeguarding Board set the following terms of reference

2.1 To identify to at what point any concerns about the safety and welfare of Subject as a consequence of her mother's mental health were recognised by any agency and what action was taken in relation to these concerns.

2.2 To identify what action was taken by any agency from June 2006 following statements by BM that she was afraid she might harm Subject.

2.3 To confirm whether or not your agency was invited to attend the multi-agency meeting held on 30th June 2006 in relation to Subject. If so, your agency's understanding of the status of this meeting and the plan that followed from it.

2.4 To describe all communication, information sharing and assessment processes undertaken by each agency.

2.5 The following agencies were asked to undertake a management review in this respect.

- The Devon County Council Children and Young Peoples Directorate
- The Devon NHS Partnership Trust
- The North Devon Primary Care Trust
- The Local GP Practice
- The Local Sure Start Programme managed by National Children's Homes
- The Northern Devon Healthcare Trust
- The Local Nursery

- The Devon & Cornwall Constabulary

3. Family Composition

3.1	Father	BF	Age 45 in 2006
	Mother	BM	Age 37 in 2006
	Children	Subject	Born 2002

4. Analysis

5.1 Sadly this Serious Case Review reflects themes from many others over the last 10 years. These are mainly based on communication, information sharing , thresholds, policies and procedures, accountability, responsibility and risk assessment.

5.2 There were many missed opportunities where earlier intervention may have made a difference to the protection Subject needed.

5.3 Had the risk to Subject been recognised following BM's admission to the hospital in January it may have resulted in a full assessment of BM's mental health problem and recognised the potential risk to Subject.

5.4 Information was shared with some agencies but not with others, for example the nursery where Subject spent 4 mornings a week. Had information been gathered in a more structured basis it might have been easier to recognise the potential risk to Subject from her mother.

5.5 Focus was lost on Subject and at times she did not seem to be considered. Within the multi-agency team the psychiatrists were ineffective in communicating clinical findings to the case holder, or to other agencies that were involved. They did not appear to be engaged in the process of multi-agency working, risk assessment or management.

5.6 The family actively sought out support but were not always responded to appropriately. They were reticent for CYPS to be involved. The husband could not be relied on to report an escalation of her behaviour. It was as if their co-operation with the other agencies e.g. Sure Start, health visiting service, GP, community mental health team and the nursery, reassured all these professionals that all was well within the family.

5.7 One of the main issues was the failure of the Children and Young Peoples' Service to accept the child protection referral. This left the community care worker with the burden of responsibility for managing the risk with inadequate information and support. From this point professionals were at a disadvantage as they seemed to lose sight of the main issue, the risk to Subject. They lost focus on the risk to Subject and focussed on parenting and Subject's behaviour management. They seemed unaware they could call a child protection case conference in their own right and also unaware of how they could escalate

their concerns to senior managers. It is all credit to the community mental health worker that she decided to hold a professionals meeting as she obviously felt there was nowhere else to go. This decision although commendable reduced the level of concern especially for the social worker. As the child protection referral had not been accepted by the CYPS it reduced his concern and he did not appear to recognise the level of risk to Subject. He had little knowledge of the family and relied on those people who knew the family better therefore reducing his level of concern.

5.8 A chronology may have helped to focus on the family and the emerging risk.

5.9 No one appeared to take full responsibility for this case nor to make co-ordinated multi-agency response. There was evidence of some good multi agency working and a willingness to do so but not all information was shared with all agencies involved. It was felt that all the agencies were doing their best but were unable to focus on the most important issue, that of Subject's safety in conjunction with her mother's escalating mental health problems.

5.10 The historical risk factors were not known although mention was made to obtain her previous medical records on a number of occasions. Although weight has been put on the fact that having BM's previous mental health records may have alerted professionals to the risk factors there was obvious evidence of her immediate risk to Subject.

5.11 Clear lines and levels of communication and information sharing need to be developed between agencies working with children and families as per existing protocols.

5.12 Health Visitors and GP's need to speak to each other directly to share information on concerns about the well being of children and families.

5.13 GP practices should facilitate an appropriate response to invitations to attend child protection conferences and strategy meetings.

5. Conclusion

This family, in the care of multi agency services, tried to engage with services but was not heard. BM threatened to harm Subject on at least 10 occasions and still she was not protected. Focus was lost on Subject amidst BM's mental health problems; professionals failed to recognise the escalation and potential dangerousness of the mental health problems. The fact that BM's threats to harm Subject were not taken seriously and she was seen as a child in need and not a child in need of protection deflected and minimised professionals' view of the reality of the situation. No one took total responsibility for the assessment of the risk to Subject hence she got lost in the system. The whole case is a catalogue of missed opportunities although there are examples of good multi-agency working of dedicated professionals. Experience has shown that if a parent/carer with previous psychopathology threatens harm to a child there is increased risk compared to someone without

that past history.
Although, the physical harm to Subject was minimal and she has made a full recovery from her physical injuries she has been left with significant emotional and psychological difficulties. Hard lessons will have been learnt without the loss of a young life.
It is a stark reminder that all agencies must remain child focussed at all times.

6. Recommendations: The following recommendations are accepted and endorsed

All Agencies

5.14 Any professional must be prepared to challenge a decision they think is not in the child's best interest and if necessary seek another opinion. (Laming Recommendation 37).

Children and Young Peoples' Service (CYPS)

5.15 CYPS and the adult mental health services protocol to be agreed and put in place by September 2007.

5.16 Awareness raising training for all CYPS managers regarding mental health of carers and their risk to children to be in place by December 2007.

5.17 All referrals and contacts must be logged by the Helpdesk on the Carefirst system.

5.18 A decision about a referral must be made by a practice manage within 24 hours. (Implemented)

5.19 Referral thresholds training must be in place for all Helpdesk staff by September 2007.

5.20 A robust supervision policy needs to be in place and standards complied with.

Devon Partnership NHS Trust

5.21 Managers need to ensure the "Children Visiting Wards Policy" to be audited to ascertain its use and suitability.

5.22 The Trust Discharge Plan must be reviewed by a nominated manager to ensure family members and staff from the community, are included in the discharge meeting.

5.23 All clinicians must be able to demonstrate that they have considered the effect a parents/carers behaviour/diagnosis may have on their ability to parent and whether as a consequence posed any risk to any children in the family. This must be recorded.

5.24 There must be a robust system in place to request previous mental health records.

5.25 A multi agency referral form needs to be developed to ensure clarity of referrals to CYPS. (Implemented)

5.26 Guidelines need to be drawn up about acceptable timescales for typing out and sending letters in response to urgent referrals.

5.27 A review (nominated manager) needs to be undertaken of Child Protection training within the Trust for staff working with children, families and perpetrators of child abuse.

5.28 Managers and clinical leads must support their staff to attend Child Protection training and commence a programme of attendance.

5.29 Staff to be reminded that when there are professional differences they must follow S7 Procedures for resolving professional differences contained within the Trust's Child Protection Protocol, Request of records.

Devon Primary Care Trust (North area)

5.29 Health Visiting/Public Health documentation should contain an assessment tool and an action plan framework.
(Implemented in Exeter and East area)

5.30 Referrals to CYPS must be followed up in writing within 48 hours as per "What to do if you are worried a child is being abused"

5.31 A paediatric liaison post needs to be created.

The Local Sure Start Scheme managed by National Children's Homes

5.31 Implement the ASPIRE paperwork and training for all home visiting work. the focus being on assessment, analysis and recording of information.

5.32 Set up a training day to look at potential sources of vulnerability a resilience in relation to assessing levels of risk.

5.33 A flow chart to be issued to remind staff of the requirements of the Death

and Serious Injury Standards.

National Children's Homes have already set up training days for the whole staff team to look at assessments, recording and sharing of information and these will be built into future planning. Within the parenting support programmes NCH will ensure there are chid centred assessments, outcomes planned for and child focussed recording. They are also part of the CAF programme and working within a clear outcomes framework

Northern Devon Healthcare NHS Trust

5.34 Consideration needs to be given to a "Safeguarding children check list" for all children attending the Accident and Emergency Department in line with threshold for referral

5.35 All adults who attend the Trust for consultation, with conditions that may have a detrimental effect on their ability to care for children, should have this information documented in their notes.

Devon and Cornwall Constabulary

5.36 On all occasions when the Police come into contact with an adult who has in their care or control of a child who may be at risk as a result of that person, or another persons action, then in all instances appropriate action must be taken to safeguard that child or any other child who may at risk of abuse, harm o neglect,

5.37 In all cases a 121'a must be submitted and the police should review its 121'a system to ensure appropriate data is captured and that there are systems in place for the dissemination of data to relevant agencies.

Helen Hyland
December 10th 2007