

Devon Safeguarding Children Board.

LSCB SCR CN03
Serious Case Review.

Executive Summary.

Regarding Subject.

Born 2006, died October 2006 (Age 2 months at death)

Written by John Ingham and Dr Jane Richards on behalf of Devon Safeguarding Children Board.

Nov 2007.

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Foreword.

- 1). This Serious Case Overview report was commissioned by Anne Whiteley, Director of Children and Young People's Service for Devon County Council, in her capacity as Chair Person of the Devon Local Safeguarding Board.
- 2). The report was written by John Ingham, Independent Social Worker assisted by Dr Jane Richards on behalf of the Safeguarding Board.
- 3). This Executive Summary has been prepared to provide a succinct and accessible summary of a Serious Case Review (SCR) undertaken by the Devon Local Safeguarding Children Board (LSCB). The report gives a summary of the reasons for the SCR, the methodology used, the lessons learned and the recommendations made. It is a publicly available document that will be published on the Devon LSCB website at;

<http://www.devon.gov.uk/index/cyps/child-protection/devonlscboard.htm>

- 4). On the evening of Saturday Sept 30th 2006 Subject was brought to the Accident and Emergency Dept. of Derriford Hospital, Plymouth. He was collapsed, not breathing and with no pulse. Subject had been pulseless and not breathing for approximately 30 minutes before arriving at Derriford Hospital. Subject was resuscitated and transferred to the Paediatric Intensive Care Unit in the Bristol Royal Hospital for Children. Medical examination conformed that Subject had widespread fresh haemorrhages in the brain and also evidence of older haemorrhages. (Subject had been without pulse or breathing for approximately 30 minutes before arriving at Derriford Hospital.) After sedation, further neurological investigations and consultation with his parents, Subject died on Oct 2nd 2006.
- 5). Given the nature of Subject' injuries there was immediate suspicion that his death could be attributed to child abuse. Further post mortem examination and ongoing Police investigations have now supported this suspicion and Subject's father, F1, has been charged with murder and is currently remanded in Custody pending trial.
- 6). Shortly after Subject' death arrangements were made for his older sister, S1, to be placed with other family members. She has since been made the subject of an Interim Care Order to Devon County Council.
- 7). Neither Subject nor S1 were, or have ever been, on Devon's Child Protection Register or the register of any other Authority. There has, however, been significant involvement from a range of health agencies as both parents and the children were affected by a number of issues in relation to their physical health and wellbeing. F1 and M1 were also in receipt of health services in relation to identified mental health issues.
- 8). The Devon Local Safeguarding Children Board has now considered the circumstances in which Subject died and has determined that the criteria are met for a

Serious Case Review as required by Chapter 8 of the National DfES Guidance “Working together to protect Children (2006).” This decision was made on the basis that:-

“A child has died and abuse or neglect is known or suspected to be a factor in the death of the child.”

Methodology.

9). The Review has been undertaken in line with advice concerning Serious Case Reviews in the Working Together Procedures 2006 and guidance from the Multi-Agency Child Protection Handbook for Devon, Plymouth and Torbay. This has since been supplanted by the South West Child Protection Procedures

10). The Review looks openly and critically at individual and organisational practise to see whether changes could or should be made and if so to identify how these changes will be brought about.

11). In producing the Review the following sources have been used. Agency Management Reports from the following have been received;-

- Devon and Cornwall Constabulary.
- Devon Partnership Trust. (West Devon Community Mental Health Team).
- Devon Primary Care Trust.(Local GP surgery.)
- Devon Primary Care Trust (Health Visiting and Midwifery Services).
- Cornwall Primary Care Trust (Health Visiting Service).
- South Western Ambulance Service.

Subject and S1 were not known to Cornwall Children’s Social Care or Devon Children and Young People’s Service.

12). Information about the midwifery service of Devon Primary Care Trust has been taken from the chronology not a report. This is also the case for the Psychology Service in the Maternity Unit at Derriford Hospital.

13). We have also had access to a report by M14, Community Paediatrician, from the Western Area NHS Trust detailing the actions, interviews and medical investigations undertaken at the Bristol Children’s Hospital following Subject’ admission.

14). Except as above, all the health agencies have interviewed the appropriate staff involved as part of their Management Review. The exception is the Cornwall Primary Care Trust who used Health Visiting written and paper records.

Terms of Reference.

15). The agencies were asked to consider the following terms of reference;-

- a). All health agencies to review chronologies of their involvement with the family and to identify any risk factors and any associated concerns that indicate missed opportunities for inter agency working.
- b). A specific analysis of the assessment by the Devon based Health Visiting Service of the information made available by the Cornwall Health Agencies with particular reference to the concerns raised by the Ante-Natal Psychologist. In particular whether this assessment triggered concerns about the risk of significant harm to S1 and then unborn Subject. If so, were standard Child Protection procedures followed?
- c). To Review the Health chronologies in relation to Subject with particular emphasis on whether the reported incident concerning Subject when it was alleged that he was dropped on the floor by his sister S1 when he was 4 weeks old was brought to medical attention.
- d). Whether minor subdural effusions and/or fractured ribs were considered as part of the differential diagnosis for the symptoms displayed by Subject in the week following the alleged dropping.
- e). To describe all communication, information sharing and assessment processes undertaken by each agency.

Analysis of Agency Involvement.

17). Before examining each agency's involvement we would wish to acknowledge a number of themes evident in this case based on the family's behaviour. Firstly it appears the agencies throughout their involvement identified similar concerns about the family at different times. These included the following;-

- The mental health of both parents relating to depression.
- A marital relationship described as ranging between strained to volatile.
- The mothers's (M1) own poor physical health.
- M1's concerns about S1's health and behaviour.
- In respect of Subject, M1's concerns about his health and her inability to bond with him.

18). Further themes, often interwoven, were;-

- M1 and F1's propensity to ask for professional help, only to often back away from this, not respond to suggestions or cancel appointments.
- M1's complaints about S1's behaviour and concerns for her health. It is a matter of speculation how much this reflected her own mood and coping ability at any one time, or whether on occasions she used this to obtain attention for herself.
- Whilst there are some exceptions, the almost exclusive professional focus on M1 rather than F1. This was not assisted by F1 not responding to the appointments he was offered.
- A propensity by M1 to play professionals off against each other.

19). Whilst all these aspects were identified no one agency seemed able to successfully grapple with them. This is reflected in the overall communication between the agencies, which often discussed these concerns, but were never able to

successfully create a plan to address them. Arguably the psychologist M9 had the most complete handle on the potential risks in the family. Whilst she communicated these appropriately to others, taken individually the issues she identified were not at a threshold of concern that were easily addressable without the willingness and co-operation of the parents. There was considerable monitoring of S1 and Subject' health and development and of M1's health but little of F1's mood or feelings despite information he had suicidal thoughts. With hindsight this is the main gap in the professional input.

20). It is also of some concern that the paediatric investigations at Bristol Children's Hospital identified injuries to Subject that were earlier in age than the timescale of Sept 30th. This review does not have access to Police evidence that has led to the arrest and charging of F1, but clearly earlier rib injuries increase the range of people who could be responsible for them.

Lessons Learnt and Recommendations.

Cornwall Primary Care Trust – Health Visiting Service.

21). The principal lesson learnt is the importance of communicating information quickly when a case leaves the area, with a clear emphasis on the Health Visitor's views, based on evidence.

- a). When children transfer between areas contact with the new area and transfer of records needs to be made as soon as possible.
- b). Cornwall PCT need to review whether with cases of Children in Need or Child Protection, the Child Protection Supervisor has communication with the counterpart in the receiving area to ensure that there is full understanding of the issues involved.
- c). It is matter for Cornwall PCT to decide whether any of the recommendations in respect of Devon's Health Visiting Service have any relevance for them.

Devon Primary Care Trust – Health Visiting Service.

Lessons Learnt.

22). Areas of good practice were:-

- a). Support was offered to this family and contact made by letter, phone and home visits.
- b). M1 was offered attendance at antenatal support group for mothers with low mood and this was followed up by a phone call.
- c). When the named Health Visitor was on leave, cover was provided and the covering Health Visitor was introduced to the family beforehand.
- d). M1 was advised to see Go with Subject when she phoned with concerns about his breathing.

23). Areas that could be improved were:-

- a). Better analysis of information received from a previous area's service.

- b). Record keeping practise.
- c). A co-ordinated approach to Children in Need or facing child protection issues across the professional disciplines in a Practice, based on face to face communication and an agreed plan that is recorded and reviewed.
- d). If screening tools for depression are used they are completed by one professional, and action recorded and followed through.
- e). If other agencies make suggestions about need or appropriate onward referrals, these need to be considered by the Primary Health Care Team as a whole, and any subsequent action implemented as agreed.
- f). Cover arrangements for Health Visitors need to be realistic with the workloads involved and equitable between surrounding Practices.

Recommendations for Actions.

24). Families moving into an area.

- a). Child health records to be requested on receipt of information that a new family had moved into the area. A record of this should be dated and signed.
- b). On receipt of the Child health records these should be fully read by the named Health Visitor and the date this was done recorded and signed.
- c). Where there is information about a family who cause concern or where another agencies is expressing concern then consideration should be given to an inter professional meeting within the Practice to decide how to proceed. Consideration should be given to inviting the parents and other relevant professionals. The purpose of such a meeting would be to create an agreed co-ordinated approach and written plan.
- d). There should be a review of Devon PCT Health Visiting Standards of Record Transfer, (South Hams and West Devon PCT 2006) and Transfer of Children Causing Concern. (South Hams and West Devon PCT 2003).

25). Initial Assessments.

- a). All information from other agencies needs to be objectively analysed if the information suggests a Child in Need or Suffering Significant Harm or likely to suffer Significant harm as defined in the 1989 Children Act. This information needs to be fully discussed with Child Protection Supervisor or Named Nurse for Safeguarding Children. That this has occurred should be recorded in the child's notes, dated and signed.
- b). All home visits to a family should be recorded in the child's health records, stating the reason for the visit, any relevant information, a plan of care, outcomes from it and how the plan is to be reviewed.
- c). There should be a review of Devon PCT Standards on Visiting Vulnerable Families. (South Hams and West Devon PCT 2004).

26). Record Keeping.

- a). There should be a review of Health Visiting record keeping, both paper and electronic, across Devon PCT. This includes a review of the Devon Standards for Record Keeping for the Health Visiting Service. (South Hams and West Devon PCT

2002). Expectations about record keeping need to be realistic in relation to other demands on Health Visitors time.

- b). All records should be contemporaneous, legible, dated, timed and signed with correct names of family members.
- c). All records should contain the reason for contact, a plan of care, outcomes and reviewing arrangements.
- d). There should be an electronic flagging system in place for practitioners keeping electronic records to ensure that other members of the Primary Health Care Team can readily identify Children in Need, at risk of Significant Harm or on the Child Protection Register.
- e). There needs to be further thought given to when written and electronic recording systems are used. A back up system for when electronic records fail or are temporarily inaccessible, needs to be available.
- f). Staff using an electronic system need to have training available to them to ensure this can be done effectively.
- g). The handover of patients between the Midwifery Service and Health Visiting Services needs to be recorded, dated and signed.

27). Communication.

- a). There needs to be face to face communication between Health Visitor and GP if at all possible, in respect of families causing concern. Systems for regularly achieving this aim need to be considered. Any discussions need to be recorded in the Child Health records, including any plans and who is responsible for which action. These should be dated and signed.
- b). All phone calls should be recorded in the Child Health records and should be dated and signed. If concerns have been expressed about a child these should be explicit in the recording, along with what action is to be taken and who is responsible for it.
- c). When staff are on leave there needs to be a handover of information that is recorded in the Child Health records and a plan of care agreed, recorded and signed.
- d). Where other agencies suggest a plan of action or onward referral this should be fully discussed with the Primary Health Care Team involved. The discussion along with any plan of care and who is responsible for each action should be recorded in the Child health record dated and signed. If no action is taken this should be documented along with the reasons for this decision and who was responsible for this. The referring agency should be informed of the decisions taken.

28). Child Protection Supervision.

- a). There should be a review of the Devon PCT Child Protection Supervision Protocol. (South Hams and West Devon 2003).
- b). When information is received about a family suggesting a Child in Need or where there are Child Protection issues, this information must be fully discussed between the Health Visitor and the Child Protection Supervisor or Named Nurse for Safeguarding Children at the earliest opportunity. This must be recorded in the Child Health records, dated and signed, with a plan of care, and who is responsible for each action.

29). Screening tools for post natal depression.

a). There should be a review of the use of screening tools for post natal depression by Devon PCT and clear guidance provided.

30). Caseload Management.

a). There should be a review by Devon PCT of the Health Visiting caseload management system.

b). Individual Locality Managers and Health Visiting Leads should review cover arrangements for Health Visiting caseloads so that these are both equitable and safe. This includes ensuring that too many staff are not on leave at the same time.

c). Practitioners must inform Locality Managers in writing of high work load pressures.

31). Devon PCT management review says that the Primary Care Trust has endorsed these recommendations and had developed an Action Plan to address the issues identified by Nov 2007.

Devon Primary Care Trust – GP Services.

32). There is overlap between the recommendations in relation to the Health Visiting Services and that of the GP Service. The most obvious of these are as follows.

33). When information is received from another agency expressing concern about a Child in Need or where there are identifiable Child Protection issues the GP needs to allocate time to do one of the following;-

a). Have a face to face discussion with the Health Visitor about the issues and then record the planning, and responsibility for actions resulting from such consultations.

b). Attend or at least contribute to any intra professional Practice Meeting about a child that may include parental participation. The aim of such a meeting would be to create a co-ordinated plan, that identifies actions to be taken, those responsible for each action and a way of reviewing the outcomes. Such meetings could be as a result of concerns about patients incoming to a Practice, about those well known where new issues arise or where there are children with complex needs.

c). With the Health Visiting Service identify systems where by cases can be discussed on a regular basis.

34). Devon PCT need to give further thought as to how these proposals can be implemented.

Devon Partnership Trust – West Devon Community Mental Health Team.

35). Whilst it is not being suggested that obvious issues were missed in this case, and M11 and the M12, the Approved Social Worker, saw nothing during their visit to raise their concerns. Nevertheless the recommendations below would make the Trust's procedures tighter.

- a). When visiting a patient the clinician must consider fully the impact of an adult's behaviour on their parenting taking into account their observations at the time of the visit and the reported history. This should include whether an adult poses any risk to a child in the family. The clinician must be able to show they have considered this in their records.
- b). It is recommended the Trust audit the use of its current risk assessment form, the criteria that trigger its use and its effectiveness in assessing risk of harm to children and others.
- c). It is the Trust's responsibility through recruitment and further training to ensure that their staff have the necessary skills and knowledge to undertake the above.
- d). It is recommended that the Trust remind staff of their policy to refer childcare concerns on to other agencies.
- e). To this end it is recommended that the Trust review the status of child protection training. Currently it is deemed essential but not compulsory. It transpired that some staff in West Devon have had no training for many years.
- f). Managers would need to support their staff to attend child protection training. It is recommended staff are updated every three years.
- g). There should be a local review of administrative support to ensure that letters providing clinical feedback are sent out promptly.

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Nov 14th 2007.

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Devon Children's Safeguarding Board