

CORNWALL & ISLES OF SCILLY

**LOCAL SAFEGUARDING
CHILDREN BOARD**

EXECUTIVE SUMMARY

SERIOUS CASE REVIEW

CHILD A

Date of birth: 30th January 2008

Date of death: 7th March 2008

1 INTRODUCTION

1.1 THE SERIOUS CASE REVIEW

This document is intended to provide an summary of the deliberations and recommendations of the Serious Case Review Panel instigated by the Cornwall and the Isles of Scilly Local Safeguarding Children Board (LSCB) relating to Child A, a male child of white, British origin, who was born on 31st January 2008 and died on 7th March 2008 when he was five weeks old.

A Serious Case Review is not intended to attribute blame is an endeavour to learn lessons and made recommendations for change which will help to improve the safeguarding and wellbeing of children in the future.

This Serious Case Review has been undertaken in line with the 2006 'Working Together to Safeguard Children' Guidance and the Serious Case Review Policy Guidance of the Cornwall & Isles of Scilly LSCB. It has been jointly commissioned by Cornwall and the Isles of Scilly LSCB and Plymouth LSCB.

The Overview Report brings together and draws overall conclusions from the information and analysis contained in the individual management reviews, information from the child death review processes and reports commissioned from any relevant interests.

1.2 CIRCUMSTANCES THAT LED TO A SERIOUS CASE REVIEW BEING UNDERTAKEN

An Ambulance was called to Child A's home at 15.44 on 3rd March 2008. They arrived at 15.53 and found him to be cold and unresponsive. Resuscitation was started, he was transferred by road to the District General Hospital and the Police were contacted. The Police reported that they were informed by the Ambulance Crew that they were treating a baby who had had serious injuries inflicted upon him. His father, Mr B, had stated that he had got up in the middle of the night and fed Child A and had accidentally banged his head against a doorframe. Child A was put to bed and Mr B reported that he later went limp whilst being held so an ambulance was called.

Resuscitation was continued at the Hospital and Child A was admitted to the intensive care unit. There was evidence of a severe head injury believed to be due to non-accidental trauma. On 4th March 2008 Child A was transferred by road to a Paediatric Intensive Care Unit 100 miles away. On 7th March 2008 brain stem tests showed that there was no possibility that Child A would recover, his life support was terminated and he died.

Child A was not subject to any order when he died.

After Child A's death, Agencies were informed that Mr B had been convicted of child cruelty towards another of his children. This child had suffered similar injuries to those suffered by Child A.

1.3 INITIATION OF THE REVIEW

A child protection strategy meeting was convened by Cornwall Children's Social Care at the Tertiary Hospital on 6th March 2008 and was attended by Representatives from Health, Social Care and the Police.

In line with part 8 of 'Working Together' procedures, Cornwall & Isles of Scilly Local Safeguarding Children Board (the LSCB) convened a serious case review sub-committee to decide whether a case review should take place regarding Child A.

Cornwall LSCB determined that a serious case review would be undertaken in respect of Child A because he was fatally injured whilst in the care of his parents and there was cause for concern as to the way in which the authority and their Board partners had worked together to safeguard him. The LSCB was further concerned as to how a neighbouring authority and their Board partners had worked together in relation to the case of the other child of Mr B who had received similar injuries as a young baby.

This Review was undertaken by a Serious Case Review Overview Panel with an Independent Chair. The Panel consisted of representatives from the Cornwall's Social Care agency, the neighbouring authority's Social Care agency, Health, Police, Probation and Cornwall's Legal Services.

An independent Author was commissioned to produce an overview report for approval by the LSCB. The terms of reference for the work can be found in Section 2 below. The overview is informed by and is based on information provided by agency representatives who undertook the agency reports and who provided additional information and clarification to the Author during the course of the review.

A clear timetable was agreed for the submission of individual management reviews and for consideration of the draft of the overview report. A final version of the overview report was agreed by the Serious Case Review Overview Panel and was formally signed off by the LSCB on 13th November 2008.

1.4 CONTRIBUTORS TO THE REVIEW

Contribution of Agencies

Individual Management Reviews were undertaken by Social Care, Police, Health and Probation Services.

Contribution of family members

Child A's mother, was visited by the Chair of the Serious Case Review Panel in May 2008 and informed that a review was being undertaken. The purpose of the review was explained to her and legal issues clarified.

Staff involvement in the review

It was decided that Staff would not be interviewed for legal reasons but contributions which had already been made by Health prior to the receipt of this advice have been included in the Overview.

2 TERMS OF REFERENCE

2.1 TERMS OF REFERENCE FOR THIS REVIEW

The specific terms of reference for the Review of Child A's case are as follow:

- *To examine the history of Child A and to provide a chronology of significant contacts with the various agencies from September 2004 until the date of his death.*
- *Within the constraints of client confidentiality and the ongoing criminal proceedings to seek information about agency involvement with Child A and his half siblings over the same timescale as is considered relevant to the purpose of the Serious Case Review.*
- *To explore critical decision-making and communication in the context of a multi-agency approach in order to identify lessons that may improve practice.*
- *To identify any gaps in compliance with, or adequacy of, inter-agency / multi-agency procedures and to make recommendations for improvement to the Cornwall & Isles of Scilly Local Safeguarding Children Board.*
- *To highlight examples of good practice, which can be adopted across agencies, as part of the learning process.*
- *To work within guidance regarding the conduct of Serious Case Review as laid out in chapter 8 of the Government's statutory guidance, 'Working Together to Safeguard Children' 2006 and in accordance with the policy of the Cornwall & Isles of Scilly Local Safeguarding Children Board.*

2.2 DELAY

It was originally planned that the Overview Report would be started in June 2008 but as a response to Ofsted requirements a separate report writer to the one originally identified had to be found. It was agreed that the date for completion of the Overview could be deferred to 16th September 2008.

Further delay was caused by the Overview report writer's need to access policy and procedure documents and to seek clarity on certain issues with agency representatives and also because of leave taken in August 2008.

The first draft of the Overview was submitted on 16th September 2008.

3 SUMMARY OF AGENCY INVOLVEMENT

3.1 CHILD A

The first agency contact with Ms C, Mr B's new partner and mother of Child A, was on 20th June 2007 when she was seen by Health at an antenatal booking clinic on 20th June 2007 when she was seven weeks pregnant.

On 27th August 2007 Ms C's neighbour called the Police to express concern for Ms C and her unborn child as she was self harming with a knife and was in possession of 20 tablets. A probationary Police Officer spoke to Ms C in the street, found her to be "*unco-operative*" and as there were "*only minor scratches to her arms*" and "*no real evidence of self harm*" he took her to her home address and left in the care of Mr B.

Between September and December 2007 Ms C was monitored five times by Midwives. She complained of abdominal pain in 2nd December 2007 and was referred to the District General Hospital.

On 11th December 2007 a Health Visitor from Devon and Cornwall Health Services visited Ms C and completed an assessment. This process identified that Mr B had a daughter by a previous relationship, both Mr B and Ms C had a previous history of depression and anxiety, Ms C was currently on anti-depressants and there was a history of domestic violence in a previous relationship. It was further established that the couple were then aged 18 and 30 and were about to move to a new address.

On 24th December 2007 Ms C was admitted to hospital with vaginal bleeding and kept in overnight. A midwife visited her at home on 28th December 2007 to complete a birth plan. This midwife reported after Child A's death that she had had concerns about Ms C's welfare during this visit because she appeared upset.

On 15th January 2008 Ms C again complained to a student midwife of abdominal pain.

Child A was born on 30th January 2008. His was a normal delivery at 39 weeks gestation and his neonatal examination was satisfactory. Ms C and Child A were discharged from hospital on 1st February 2008.

Ms C and Child A were visited by Midwives five times between 2nd February and 11th February 2008. It was recorded that Child A was being breast fed and had regained his birth weight by 11th February 2008.

The next contact with any agency was on 15th February 2008 when Health carried out a routine home visit. It was noted that Child A had a "*small split behind (the) left ear caused by nail.*" He was referred immediately to the G.P. who recorded that he had examined a "*traumatic split to skin behind left ear*" and that there was no clear cause. He also identified a finger infection for which he prescribed Fucidin cream. Following this consultation with the G.P. Health completed routine advice to Ms C and also Child A's neonatal hearing screen which was found to be normal. Health recorded that a review would be undertaken in three weeks to complete a post-natal depression screening.

Child A was seen again by his G.P. on 18th February 2008. He recorded that the wound was healing nicely, that no action was required and also prescribed medication for Child A's oral thrush.

An urgent appointment was made for Child A at the G.P. surgery at 11a.m. on 3rd March 2008 but he did not attend. No reason was recorded for the appointment. An Ambulance Crew were called to Ms C and Mr B's home at 15.44pm on the same day, arriving at 15.53pm. Resuscitation was started on Child A and he was transferred to the District General Hospital. Child A was found to have serious injuries which had been inflicted upon him.

Mr B informed Police that he had accidentally hit Child A's head against the door frame when he got up in the night to feed him. He put Child A to bed and later, whilst being held, he went limp. This was when the ambulance was called. Health records state that there "*was evidence of severe head injury believed to be due to non-accidental trauma.*" The Police treated the incident as suspicious due to the nature of Child A's injuries and Mr B was charged with murder. During the period of the serious case review Mr B was on remand in prison awaiting trial.

Resuscitation of Child A continued in the District General Hospital and on the following day he was transferred, on life support, to the Paediatric Intensive Care unit of a Tertiary Centre 100 miles away.

A child protection enquiry meeting was arranged by Cornwall and held on 6th March 2008. It was attended by agency representatives from Health, Social Care and the Police.

On 7th March 2008 Health recorded that brain stem tests showed that Child A had no possibility of recovery. Life support was terminated and he died in the presence of both Ms C and Mr B.

4 CONCLUSIONS / LESSONS LEARNED FROM THIS REVIEW

4.1 CONCLUSIONS

The overview analysis addresses the key areas of agency involvement in Child A's case including: multi-agency safeguarding; assessments, analysis and recording; management and supervision; the tracking of offenders and domestic violence.

The Overview findings are that there were four key opportunities for professionals in Health and the Police to have intervened positively in Child A's case and had any of these been taken it is almost certain that he would have been safeguarded. This is because his father's history would have come to light. The Overview has further highlighted that there were opportunities for agencies to have acted differently after Mr B's other child was injured which could have led to his whereabouts being tracked. This would have given agencies the opportunity to give appropriate information to Ms C and to ensure that Child A was safeguarded.

The failures to take action were not, generally, caused by a lack of appropriate policies and procedures but because:

- *Multi-agency child protection procedures were not always followed by professionals resulting in limited information being available to some agencies.*
- *Although there was some good communication between agencies some agencies failed to pass on crucial information to each other and one agency failed to share information internally.*
- *Professionals did not carry out their duties as if they were part of a multi-agency team and tended to view the information that they obtained in isolation. This meant that its significance was not recognised, the information was not analysed and interventions were not revised in the light of it.*
- *Practitioners offering services to adults did not always meet their statutory responsibility to address safeguarding issues in relation to children/unborn children.*

The Overview also found a general lack of evidence of management overview and scrutiny of cases across all agencies and a lack of awareness amongst professionals of issues relating to domestic violence.

4.2 LESSONS LEARNED FROM THIS OVERVIEW

The Overview stated that the following lessons should be learned from Child A's case:

- *The mere collection and recording of information does not safeguard children. Records in all agencies need to differentiate between fact and opinion and should contain analysis which includes assessment, clear recommendations and timescales for action. Records should be updated when new information is received.*
- *When information is received by one agency professionals should always consider whether it should be shared with any other agencies before deciding to take no further action.*

- *It is often not until information is shared between professionals that meaning can be attributed to it. Practitioners should, therefore, routinely share information about children and their families with professionals in their own agencies and in other agencies (with due consideration to data protection issues) in order to ensure that children are safeguarded.*
- *Records of visits to service users should be accessible by other professionals in the same agency and professionals working with the same family should ensure that they read the records of colleagues to inform their own assessments.*
- *Whenever professionals have any concerns about a situation relating to the welfare of a child and/or a pregnant woman living with a man they should make enquiries of the Police to establish whether the man is known.*
- *Unusual injuries to babies under six months should always alert professionals to the possibility that they may have been physically abused.*
- *Even when an agency's primary client/identified client is an adult, professionals in the agency have a statutory duty to identify safeguarding issues for children.*
- *Assessments should be allocated and undertaken in a timely manner to ensure that the widest possible consultations with partner agencies can be undertaken.*
- *Managers/supervisors should not rely on the reports of professionals that they have undertaken work but should seek to verify this through reading file records.*
- *Managers/supervisors should check that all outstanding work has been completed prior to authorising a case closure.*
- *Whenever a parent is charged with an offence against a child, professionals in all the agencies involved should, in discussion and agreement with partner agencies, put plans in place to ensure that current children and possible future children are safeguarded. In such situations the use of Category 3 of the MAPPA Guidance should always be considered.*
- *It is vital that Safeguarding Units are informed when Offenders who have received a custodial sentence for an offence against a child are released from custody.*
- *If Probation files of Offenders who have been convicted of an offence against a child are destroyed within 10 to 15 years of the expiry of a Probation Order it is highly possible that information that could later prove vital to safeguard another child of the Offender, could be lost.*
- *It is very important that safeguarding issues are embedded in decisions made by the Crown Prosecution Service relating to criminal charging.*
- *It is crucial that research findings relating to the links between domestic violence and pregnancy are brought to the attention of practitioners and managers in all agencies so that appropriate actions are taken to safeguard women and their unborn children.*
- *Professionals in all agencies need to be mindful of research findings showing a link between domestic violence and child maltreatment.*
- *Women should be seen alone at least once during the ante natal period and need to be routinely asked whether they are experiencing domestic violence*

5. RECOMMENDATIONS

Recommendation 1 – Safeguarding Issues: Plymouth LSCB and Cornwall and IOS LSCB and Member Agencies:

All agencies must ensure that their staffs continue to understand the importance of sharing information within and between agencies whenever any concern, however, apparently insignificant, arises about a child or unborn child.

Recommendation 2 – Safeguarding Issues: Plymouth LSCB and Cornwall and IOS LSCB Agencies:

Whilst the child's welfare is paramount, all agencies must ensure that their staffs are reminded that whether their primary client is a child or an adult, they have a statutory responsibility to identify and address safeguarding issues for both children and adults.

Recommendation 3 – Safeguarding Issues: Plymouth LSCB and Cornwall and IOS LSCB Agencies:

All staff in partner agencies should have access to a designated safeguarding advisor in their own agency and should also be able to obtain advice from Social Care professionals without necessarily having to make a referral to Social Care. Staff should be encouraged to contact their advisor whenever they are uncertain about a potential safeguarding issue or are unclear what actions to take to safeguard a child. Contact details for these advisors should be provided to all practitioners and managers and included in each agency's Safeguarding Procedures.

Recommendation 4 – Safeguarding Issues: Plymouth LSCB and Cornwall and IOS LSCB Agencies:

All agencies must ensure that when practitioners are undertaking any risk assessment in relation to a child, they are reminded to enquire fully into the background of parents and include information from previous families / children.

Action should be taken on the above recommendations within three months of the conclusion to this Serious Case Review.

Recommendation 5 - Safeguarding Issues: Plymouth LSCB and Cornwall and IOS LSCB Agencies:

All agencies are reminded that when concerns exist about a person that are not strong enough to make a referral to the Police or to another appropriate agency they may contact the Police Central Referral Unit to make enquiries to establish whether a person is known.

Recommendation 6 – Recording: Plymouth LSCB and Cornwall and IOS LSCB Agencies:

When practitioners are required by their agency to use an assessment tool in their work with their clients they are trained in its use and interpretation and there is a clear understanding of the expectations of the organisation in respect of what actions should be taken on the outcome of the assessment, particularly where the assessment may have safeguarding implications.

Recommendation 7 – Tracking Offenders: Plymouth LSCB and Cornwall and IOS LSCB Agencies:

Devon and Cornwall MAPPA Strategic Management Board to contact the responsible authority national steering group to request that a proposal is made to extend the legislation in the identification and management of MAPPA Offenders. The extension would be either:

- A) To add to MAPPA category 2 All adult offenders who are convicted of offences of cruelty to or violence against children regardless of sentence; or
- B) To introduce a new category which specifically relates to offences against children (excluding sexual as these are captured in Category 1) to be managed at all three MAPPA levels.

Recommendation 8 – Tracking Offenders: Plymouth LSCB and Cornwall and IOS LSCB Agencies:

Devon and Cornwall police have introduced a system whereby all nominal convicted of offences against children are identified and have a warning marker with advice on their electronic case record. This includes notification to the Public Protection and Child Abuse Investigation Unit.

Devon and Cornwall police will undertake an annual audit, which will sample records to determine the effectiveness of the warning marker and notification system. If required, recommendations for improvements would be implemented.

Recommendation 9 – Tracking Offenders: Plymouth LSCB and Cornwall and IOS LSCB Agencies:

Devon and Cornwall Police and Devon and Cornwall Probation Area will review their safeguarding children policies against practice, to ensure that processes are in place whereby relevant managers have considered convening a multi-agency strategy meeting in the case of a parent being charged and/or convicted of an offence against a child. The decision should be clearly recorded in line with agencies recording policies.

Recommendation 10 – Tracking Offenders: Plymouth LSCB and Cornwall and IOS LSCB Agencies:

Devon & Cornwall Police, Devon & Cornwall Probation Area and the Prison Service responsible for the development and outcomes of the above recommendation (7 8 & 9) should report to the MAPPA Strategic Management Board. The MAPPA SMB will take responsibility for reviewing the implementation of the recommendations, also ensuring that relevant information is disseminated to staff. The Chair of the Devon and Cornwall MAPPA SMB will report to the Plymouth and Cornwall Local Safeguarding Children Boards on the progress in relation to these recommendations.

Recommendation 11 - Supervision and Management: Plymouth LSCB and Cornwall and IOS LSCB Agencies:

Within three months from the conclusion of this Serious Case Review, all agencies to review staff supervision to ensure work is scrutinised and signed off by managers and that cases are audited regularly. Arrangements should be made for the findings from the audits to be reported to senior managers in each organisation at least bi-annually. The arrangements should be Climbie compliant.

Recommendation 12 – Devon and Cornwall Health Agencies:

All Health practitioners should use secure patient record systems, maintained by the employing organisation, which allow free text entries on all client contacts and which can, in line with the record policies of the organisation, be made available to other health professionals who may have clinical involvement with the client.

Recommendation 13 – Devon and Cornwall Health Agencies:

Training for Health staff should reinforce the need for practitioners dealing with children and families to be prepared to act on their own assessments and to challenge the decisions of others where there are differences of opinion in relation to safeguarding.

Recommendation 14 – Devon and Cornwall Health Agencies:

Training records for key Health staff should be maintained by the employing organisation so that individuals do not miss out on regular training updates. Child Protection training should be a standard item in all appraisals of health practitioners.

Recommendation 15 – Devon and Cornwall Health Agencies:

Health Visitors and Midwives should arrange to see all pregnant women / new mothers at least once on their own and consideration should be given as to whether routine questions relating to issues of possible domestic abuse should be asked at such meetings. Any resistance on the part of either parent to the woman meeting a health professional alone should be discussed with a manager and a plan developed to ensure that the situation is monitored and the safety of the unborn child is considered. Where appropriate Plymouth or Cornwall Children's Services should be alerted.

Recommendation 16 – Devon and Cornwall Health Agencies:

Health Visitors and Midwives should routinely ask questions about parents' previous experience of parenting and obtain as much information as possible about children who are living apart from their parent and / or with whom they are no longer in touch.

Recommendation 17 – Devon and Cornwall Health Agencies:

Health Visitors and Midwives should be advised to seek the advice of a manager or safeguarding officer whenever they find an unusual injury on a baby. They should ensure that the child is medically examined and should also consider making an enquiry or a referral to Children's Social Care.

Recommendation 18 – Devon and Cornwall Health Agencies:

A review should be undertaken within three months of the completion of this Serious Case Review to ascertain whether all GPs have undertaken multi disciplinary child protection training within the past three years

Recommendation 19 – Devon and Cornwall Police:

Devon and Cornwall Police should ensure that the work on the assessment of force child protection training currently underway is completed within three months of the conclusion to this Serious Case Review.

Recommendation 20 – Local Issues: The Probation Service:

Within one month of the conclusion of this Serious Case Review the Local Probation Chief Officer for Devon and Cornwall Probation Service to notify staff of the findings emerging from this Review which relate to the Probation Service and help establish local safe practice:-

- Ensuring that Probation Officers are aware that the child's welfare is paramount and must be considered in all assessments of and work with Offenders.
- Undertaking a review to determine whether current child protection training courses for Probation Officers give sufficient emphasis to the requirements of Section 8 of the 'Statutory Guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004'. If any gaps in training are identified additional training should be provided.
- Offering training to Probation Officers to inform them of research findings regarding the links between domestic abuse and child abuse.

Recommendation 21 - National Issues: The Probation Service:

Within one month of the conclusion of this Serious Case Review the Local Probation Chief Officer for Devon and Cornwall Probation Service and the LSCB Chairs from Cornwall and Isles of Scilly LSCB and Plymouth LSCB should notify the Home Office of the findings emerging from this Review in relation to the compilation of Standard Delivery Reports which suggest that consideration should be given to the following actions:

- Pre-sentence reports should be allocated to Probation Officers as soon as possible after the Offender's case is adjourned for sentencing to ensure that there is the maximum possible time for relevant enquiries to be made.
- Probation Officers should contact other agencies at the earliest opportunity to seek information about the offender and their family.
- Reports from Offenders about their previous offences of their own behaviour towards their children should be verified with other agencies whenever possible.
- Reports from Offenders of 'one-off' incidents of domestic abuse should be treated with some scepticism and investigated further.

Recommendation 22 - National Issues: The Probation Service:

Within one month of the conclusion of this Serious Case Review the Local Probation Chief Officer for Devon and Cornwall Probation Service and the LSCB Chairs from Cornwall and Isles of Scilly LSCB and Plymouth LSCB should notify the Home Office of the findings emerging from this Review regarding the inability of the Probation Officer to access an offender's file because of the current timescales in place for the destruction of Probation files. The LSCB should suggest that the Home Office may wish to consider whether files should be retained for longer in cases where adults have been convicted of offences relating to the injury / abuse of children and / or assaults comprising domestic abuse.

Recommendation 23 – National Issues: The Probation Service

Within one month of the conclusion of this Serious Case Review the Local Probation Chief Officer for Devon and Cornwall Probation Service and the LSCB Chairs from Cornwall and the Isles of Scilly and Plymouth LSCBs should notify the Home Office of the findings emerging from this

Review relating to the need for better communication between prisons and Safeguarding Units when offenders are released from custody. It should be suggested that a system should be put in place to ensure that letters are sent to named persons in Local Safeguarding Units together with a reply slip which can be returned confirming receipt of the information.

Recommendation 24 - National Issues; The Crown Prosecution Service:

Cornwall and the Isles of Scilly LSCB and Plymouth LSCB should recommend to senior representatives in the Crown Prosecution Service that consideration should be given to the findings of this Overview after criminal proceedings against BS have been concluded. This is in order to determine whether procedures should be developed to ensure that safeguarding issues are embedded in the CPS decision-making process in relation to criminal charging. The purpose of this process would be to ensure that the safeguarding of children is of paramount consideration when determining the charges brought against those who commit offences against children.