

**PLYMOUTH
SAFEGUARDING
CHILDREN BOARD
Executive Summary
Child A
December 2010**

INTRODUCTION

1. Child A died aged 4 months old as a result of a violent incident. During his/her short life Child A lived with his/her mother and 6 year old sibling. Although it is unclear whether Child A's father lived permanently with the family, he played a significant role in Child A's life and frequently shared his/her care. Child A's father has subsequently pleaded guilty to manslaughter and was sentenced to three and a half years imprisonment in December 2010.
2. Child A's family had contact with a number of local agencies both before and throughout his/her life. Both parents had had contact with some of these agencies during their own childhood and adolescence.
3. The purpose of this document is to provide an overview of the outcomes and recommendations of the serious case review commissioned by Plymouth's Safeguarding Children Board into a serious incident involving a child.
4. The aim of a Serious Case Review is not to assign blame, but to ensure that lessons are learned and recommendations are made to the agencies involved in order to avoid similar situations in the future.
5. In the interest of public immunity names will not be used in this document. Instead an individual's title or position they held will be cited, for example mother, child or Children's Social Care services, police etc.
6. The Serious Case Review (SCR) was commissioned by the Chair of the Plymouth Safeguarding Children Board on 1st December 2009, and looks at the circumstances surrounding the death of Child A, following an incident in November 2009 when the child received a life threatening non accidental injury whilst in the care of the child's father. Child subsequently died in the Paediatric Intensive Care Unit 3 weeks later when he/she was 4 months old.
7. If you would like further information about Serious Case Reviews please refer to the "Working Together to Safeguard Children" document published by the Department of Children, Schools and Families (DCSF).

BRIEF CASE HISTORY

8. On a weekend afternoon in November 2009, the child's father dialled 999 requesting an ambulance from the home address. The ambulance response car arrived on the scene within 7 minutes and commenced paediatric resuscitation. Child A was transferred via ambulance to hospital, arriving at the Emergency Department 21 minutes after the initiating call. Child A's sibling Child B was present in the home with the child's father at the time of the incident. Child A's mother was not.
9. On arrival at the Emergency Department, Child A was pale, cold, floppy and making no respiratory effort. Successful initial resuscitation and treatment were delivered in the department. Child A underwent a cranial CT scan, which revealed a large chronic bilateral subdural haemorrhage and acute haemorrhage in the left occipital region

10. The police were called to the hospital as the injuries were suspected to be non-accidental by the treating hospital doctor. The parents were both arrested at the hospital on suspicion of assault (GBH). The mother was released on bail to be with Child A at the hospital, and the father was remanded in custody.
11. A decision was made to transfer Child A to a specialist hospital to receive treatment. Child A sadly died 3 weeks later.
12. The father has been remanded in custody since the incident. Following Child A's death he had been charged with murder of a child under 1 year to which he pleaded not guilty. In November 2010, the father pleaded guilty to manslaughter and was sentenced to three and a half years in prison in December 2010.

THE SERIOUS CASE REVIEW PROCESS AND TERMS OF REFERENCE

The purpose of the Serious Case Review was:

13. To examine openly and critically individual agency practice in order to establish whether there are lessons to be learnt about the way that local professionals and organisations work together to safeguard children and promote their welfare.
14. To identify what those lessons are, and how they will be acted on and what is expected to change as a result.
15. To determine what actions may be needed or improvements in inter agency working in order to better promote and safeguard the well-being of children and young people.
16. The Independent Chair of the Plymouth Children Safeguarding Board is Jim Gould. The Serious Case Review Panel is chaired by Mike Craddock, an Independent Chairperson, and made up of representatives all the agencies
 - Designated Nurse for Safeguarding Children
 - Designated Doctor for Safeguarding Children
 - Detective Chief Inspector, Devon and Cornwall Constabulary
 - Safeguarding Manager, Children's Social Care
 - Principal Educational Psychologist
 - Any other seconded member as appropriate.
17. Each agency that was involved at the time of the incident, or had been, involved with members of the family in the past, was asked to complete a chronology and an Individual Management Report.

18. In order to understand the history of the mother and the father individually and therefore the experiences that they each brought to parenting, the Individual Management Report authors were to consider all historical information held by their agency and produce a full summary of any significant factors that may be needed to inform the Individual Management Report. This would then enable the Individual Management Report author to identify if this information was taken account of in any assessment of the parents, their individual needs and ability to parent.
19. The chronologies for the Individual Management Reports commenced on the 1st June 2002 and finished on the date of the incident.
20. The Serious Case Review Panel received and considered Individual Management Reports carried out by the following agencies:
 - Plymouth City Council, Services for Children & Young People, Learner and Family Support & Lifelong Learning (LFSLL)
 - Plymouth City Council, Services for Children & Young People Children's Social Care, (Children's Social Care)
 - Plymouth Hospital NHS Trust (Hospital Services)
 - NHS Plymouth Teaching Primary Care Trust (GP)
 - NHS Plymouth Teaching Primary Care Trust (Provider Services- Health Visitors and School Nurses)
 - South Western Ambulance Service NHS Trust (Ambulance Service)
 - Devon and Cornwall Constabulary (Police)
21. Each Individual Management Report contained a comprehensive chronology of the agencies' involvement with the family during the period covered by the review. These individual chronologies were combined into one integrated chronology.
22. All the authors of the Individual Management Reports are independent and have not been directly concerned with the child or family, or the immediate line manager of the practitioners involved.
23. An Independent Overview Report Author, Eithne Sharp, was commissioned to provide a report based on the Individual Management Reports, to include an analysis of single agency and multi agency working, identifying and making recommendations from the lessons learned from the review. Although independent of the Panel, the author met and liaised with the panel members throughout the process to discuss the progress and implications of the review.

24. The Individual Management Report authors were to address in detail the following matters:
 - Any assessments and interventions with the family.
 - The work of the agency in a multi agency context.
 - The involvement of family members in any assessments or interventions.
25. It was considered appropriate to ask family members to contribute to the review if possible. The father remained in custody throughout the period of the review and therefore it was not possible to involve him due to criminal proceedings. The panel took advice from the Police and the Crown Prosecution Service on the desirability of interviewing other family members. Due to the ongoing criminal proceedings, this was not considered to be appropriate until November 2010 when Child A's mother was contacted but declined to make any contribution. Through his solicitor, Child A's father was informed of the Serious Case Review.

LESSONS LEARNED

26. Following the completion of the Serious Case Review a number of lessons were identified:
27. Child A's tragic death was the result of a violent incident, and his/her father has pleaded guilty to manslaughter.. There are no indications in any of the Individual Management Reports that either Child A, or his/her older sibling, had been subjected to physical ill treatment prior to this incident and consequently there are no suggestions that agencies missed signs of actual abuse, or could have predicted, or prevented, Child A's death.
28. Nevertheless, there were indicators that this was a family in need and the children were vulnerable. These indicators were known about by various agencies and professionals involved in providing services to them, but they were never properly taken into account in any of the interventions or assessments undertaken.
29. Effective assessment and decision making require a thorough understanding of the historical context within which current events are set. It is essential that those making judgements should have access to, and make full use of relevant existing case material. In each of the Individual Management Reports the agencies have acknowledged the need to review parental past history, which is supported by research.
30. Although both parents had apparently fractured relationships with their wider family, the inter-familial and inter generational relationships were enmeshed. The wider family culture continued therefore to be relevant to the parents and the children. This culture included child abuse, domestic violence and the abuse of alcohol, and children being frequently cared for by relatives. The Police are the only agency that raised the misuse of alcohol and drugs as an issue. This should have been considered in the assessment processes undertaken by all the agencies.

31. Management and supervision networks for many of the professionals involved were not well defined, if they existed at all. There was an absence of a management overview of the services offered to the family by the majority of the agencies.
32. As with many SCR's interagency communication emerged as a key issue. Guidance published in Every Child Matters reinforced the principle that the safeguarding of children is a responsibility shared by all the agencies involved with working with Children and Families. A number of Individual Management Reports suggest that workers may not have understood this principle.
33. The need for all professionals across the spectrum to record and share information about vulnerable children was a feature of the Individual Management Reports. A number of agencies were involved but the interventions were largely isolated. There were no multi agency discussions outside of the school setting and no co-ordinated strategic planning. Information was not routinely shared. There were examples where communication could and should, have been of a higher standard.
34. It is very important always to include fathers of children in any assessment, even if they are not actually living in the home. The parenting capacity of fathers/partners must be considered as part of any assessment process. This must be incorporated into procedures and training and specifically highlighted on CAF forms or any other relevant documentation. All agencies should raise their awareness of fathers and partners who may be less visible, but should be involved in all assessments. In this instance there was a lack of any assessment of parenting capacity jointly as two parents interacting together. There were several occasions when fuller information about the father could have been elicited:
35. The impact on children of living within a household characterised by domestic violence had not been fully appreciated by some agencies involved with the children. The Police officers need to be more rigorous in documenting when children are present at incidents and making enquiries about their safety and welfare.
36. The early identification of need and the need to be vigilant in relation to risk factors that may indicate actual or potential vulnerability is a crucial lesson learned, as is the need to ensure that practitioners from all professions have a knowledge and understanding of what constitutes neglect.
37. The knowledge held by a GP is frequently crucial to the assessment of risk and the GP's role in disseminating and sharing such information is crucial, particularly with pregnant mothers and young children. The process is reliant on the significance of the information from other agencies and health professionals being recognised by the GP.
38. The standard of recording information across the agencies, with some notable exceptions, was poor. When working with vulnerable children and families in a multi agency environment, recording must be accurate, contemporaneous and detailed. Dates of interventions alone are not sufficient.

39. The Common Assessment Framework is promoted in statutory guidance and, as with many areas of the country, the partner services in Plymouth have been refining the practice and processes around its use since April 2006. In Plymouth's case, CAF was introduced in 2008, and prior to that date a Child Concern model was in place. It is evident that there needs to be greater clarity and consistency about its use.
40. A review of the Executive Summaries of 10 previous Serious Case Reviews undertaken by Plymouth Safeguarding Children Board since 2005 reveals that there have been a number of similar concerns raised in past reviews. In particular the issue of police sharing information with other agencies (Recommendation 9) has been a feature in PB (2005), MR (2006) LB (2006) and LB (2007). The failure of agencies to review all historical information on children about whom referrals are made or there is concern is noted in MR (2006) and M (2008). The latter also raised concern about Health Visitor and GP communication as well as concerns regarding the protocols in respect of transferring cases from midwives to Health Visitors.
41. More generally the need for more robust child protection supervision processes featured in 2 previous reviews and the need for better interagency communication and training was raised regularly.

RECOMMENDATIONS

42. The following recommendations include those made in the Individual Management Reports and by the Overview Report author. These recommendations are all subject to an Action Plan, which will be monitored by Plymouth Safeguarding Children Board to ensure that they are fully implemented.

RECOMMENDATIONS

Plymouth Teaching Primary Care Trust (GP) Single Agency IMR Recommendation

Recommendation 1: Where other primary health professionals are involved with a child, General practitioners should ensure they share information.

Plymouth Teaching Primary Care Trust (GP) Overview Report Recommendations

Recommendation 2: The Plymouth teaching Primary Care Trust should consider, and report to the Plymouth Safeguarding Children Board on the development of a system to ensure effective communication between the various health professionals, if possible by using secure email or other electronic means.

Recommendation 3: The Plymouth teaching Primary Care Trust should ensure that all medical practitioners and health professionals are aware, through training and the dissemination of research, of how to recognise and record cumulative medical symptoms which may indicate neglect. This should include developing a process for including a chronology in the medical notes.

Plymouth City Council, Services for Children and Young People (Learner and Family Support and Lifelong Learning) Single Agency IMR Recommendation

Recommendation 4: All agencies must follow the Information Sharing Guidance 2008 DCSF.

Recommendation 5: The CAF process should be used according to local and national guidance.

**Plymouth City Council, Services for Children and Young People
(Learner and Family Support and Lifelong Learning)
Overview Report Recommendations**

Recommendation 6: Learner and Family Support and Lifelong Learning should review the Child Protection Procedures and Guidance available in Primary Schools¹ to ensure that it is both accurate and updated and that it includes specific information about the effect on children of domestic violence. It should subsequently further review similar procedures within its service.

Recommendation 7: Learner and Family Support and Lifelong Learning should take action to ensure that policies and procedures are developed so that all staff and support staff working formally, and informally, with parents receive appropriate training, support and supervision appropriate to their experience and qualification. The training should include child protection awareness and effective recording.

Recommendation 8: Teachers must always consider a CAF when they are unable to establish the cause of a child's behaviour difficulties.

**Devon and Cornwall Constabulary
Single Agency IMR Recommendations**

Recommendation 9: Implement the changes identified in the internal review (which looked at the entire process from first contact with children and young persons through to referral) of the 121a (child referral) process.

Recommendation 10: Public Protection training relating to risk management of all safeguarding areas (Child Abuse, Vulnerable Adults, MAPPA, Domestic Abuse and Missing Persons) to be delivered to all appropriate members of staff (see action plan) within the Devon and Cornwall Constabulary.

Recommendation 11: Implement the Domestic Abuse, Stalking and Harassment (DASH) risk assessment model in the Devon and Cornwall Constabulary.

Devon and Cornwall Constabulary Overview Report Recommendation

Recommendation 12: Devon and Cornwall Constabulary to ensure that frontline staff are aware of their responsibilities to safeguard and protect any child or young person who is involved in a domestic violence incident, and to take steps to ensure that the immediate welfare of the child is secured, whatever the outcome of the investigation.

NHS Plymouth Teaching Primary Care Trust Single Agency IMR Recommendations

Recommendation 13: Improvement in communication and information sharing between maternity and 0-19 service.

Recommendation 14: Development and implementation of Child Protection Supervision policy by Children's Speech and Language service.

Recommendation 15: Speech and language service assessment of a child's needs to incorporate Framework for Assessment, to consider impact of environmental factors and parenting capacity on safety and well-being of the child.

NHS Plymouth Teaching Primary Care Trust Overview Report Recommendation

Recommendation 16: The Provider Services service should consider how they can integrate, or cross reference information contained in the child's records held by the various professionals within the agency. In particular, records of previous family history.

Recommendation 17: The Heath Visiting Service should review its arrangements for assessing cases to receive a universal or targeted/enhanced service. Protocols should be developed to deal with the reviewing and re- categorising of cases when circumstances change.

Plymouth Hospitals NHS Trust Single Agency IMR Recommendations

Recommendation 18: Staff who works predominantly with children and families should have access to Child Protection Supervision.

Recommendation 19: The midwifery documentation should demonstrate that an assessment has been undertaken in relation to safeguarding children and promotion of their welfare.

Recommendation 20: There needs to be improved communication between Health Visitor and Midwife at point of transfer.

Recommendation 21: All Clinical Psychologists working with children to attend CAF training.

Plymouth Hospitals NHS Trust Overview Report Recommendations

Recommendation 22: Ensure that the Midwifery service record information in respect of their contact with patients, including information about support and family. Through training and policies and procedures, reiterate the need to provide the Health Visiting Service with sufficient information about their involvement.

Recommendation 23: Ensure that all services provided by the hospital are aware of their responsibilities under Section 11 of the Children Act 2004 of sharing information and assessing any potential impact on children of carers with problems.

Plymouth City Council Children's Social Care Single Agency IMR Recommendations

Recommendation 24: When a Team Manager makes a decision to NFA an Initial Assessment they must ensure that all historic information held on the family has been considered.

Recommendation 25: When Out of Hours are requested to visit a child because it has not been possible for day time services to undertake an assessment, the day time Team Manager must ensure that an Initial Assessment is completed.

Recommendation 26: When undertaking an Initial Assessment entry to the family home of the child must be gained.

Plymouth City Council Children's Social Care

Overview Report Recommendations

Recommendation 27: Children's Social Care should review the processes in place to ensure that a chronology of previous family history is either uploaded onto the Care First system, or a pathway to access the information is clear on all case files.

Recommendation 28: Children's Social Care should ensure that there is always management oversight of all Child Protection referrals and investigations and that the decisions for further action are always recorded, including a decision that a child will not be seen.

Recommendation 29: Children's Social Care should review the policy and procedures in respect of thresholds for initial assessments in light of the recommendation in the Serious Case Review in respect of MR (2005).

Overview Report Inter-agency and PSCB Recommendations

Recommendation 30: Children's Social Care, Police, Health and all relevant agencies, to jointly devise and implement procedures and a workable system for the submission of, and response to police child incident reports, as a matter of urgency. As an interim measure, a sample audit of child incident reports submitted by the police to Children's Social Care, since the recommendation of the SCR of MR (December 2005) should take place immediately.

Recommendation 31: Plymouth Safeguarding Children Board to agree a process with all the agencies by which they review their systems, both paper and electronic, to ensure that staff are clear and confident about identifying and recording and referring on significant information. This to include how to use existing information when new information is received, or cases are transferred between workers in the same agency.

Recommendation 32: Plymouth Safeguarding Children Board should require that all agencies undertake a review of their staff's use of electronic systems and secure email to store, transfer and share information in respect of children and families in a more efficient way, which accurately reflects modern communication practices.

Recommendation 33: Plymouth Safeguarding Children Board, through training and audit, ensure that due weight is given to the role of fathers in the lives of children in need and children who may be at risk of significant harm.

Recommendation 34: Plymouth Safeguarding Children Board, taking account of recent research available, should take steps to raise the potential of dental neglect in children and the significance of dental care for children. They should initiate targeted training specifically relating to dental practitioners and their role and responsibility for safeguarding children and sharing information with other agencies.

Recommendation 35: Plymouth Safeguarding Children's Board should consider extending the scope of any future Serious Case Review to at least 7 days beyond the critical incident (or date of death) to allow for all the significant facts about the case being available to the SCR sub group, IMR authors and the overview report author.

Overview Report National Recommendations

Recommendation 36: The relationship between oral health and child maltreatment should be considered a priority for future research. The diagnostic criteria for dental neglect in children should be agreed and established, and thresholds for intervention agreed by the relevant professional bodies in consultation with Government Departments.

Eithne Sharp
Independent Overview Report Author

12/12/10