Northamptonshire Safeguarding Children Board

The Overview Report

into a

Serious Case Review of the Circumstances Concerning

Child I - Kieran Lloyd

Independent Author
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CONFIDENTIAL

(UNLESS PUBLICATION AGREED BY LSCBN)

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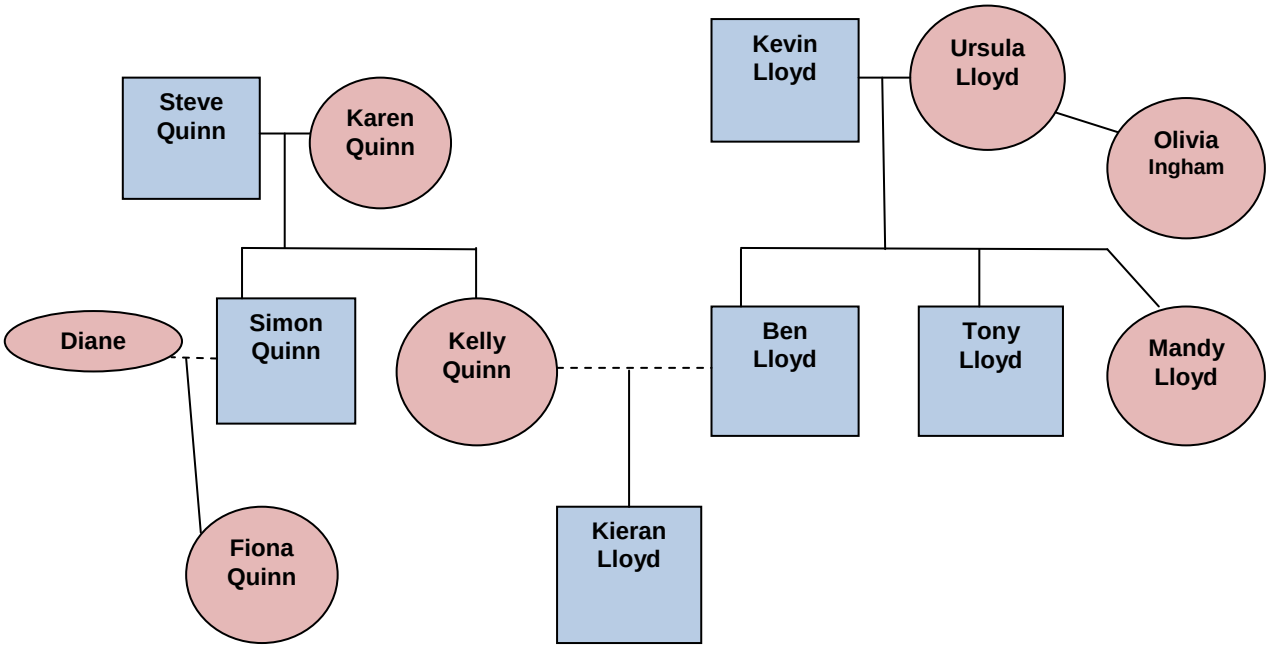
Genogram


Steve Quinn
Karen Quinn
Kevin Lloyd
Ursula Lloyd
Olivia Ingham
Diane
Simon Quinn
Kelly Quinn
Ben Lloyd
Tony Lloyd
Mandy Lloyd
Fiona Quinn
Kieran Lloyd

1. Introduction

1.1 Who was Kieran Lloyd?

1.1.1 Kieran was the only child of Kelly Quinn and Ben Lloyd. He was less than two months old when he died as a result of severe trauma which occurred when he was in the care of his parents.

1.1.2 Until his death Kieran was a healthy baby who had reached the appropriate milestones. Information from medical professionals who saw the interaction between Kieran and his mother suggest that appropriate care and the needs of the baby were fulfilled by his mother. This was observed by professionals both in hospital and community midwives whilst visiting mother and baby at home. The baby was seen to be well fed, clean and bonding with his mother.

1.1.3 Very little is known by professionals about the interaction between Kieran and his father Ben Lloyd, although there are suggestions that there had been occurrences of domestic abuse as well as police 'raids' within the household whilst Kieran was present.

1.1.4 It should be noted that in this Overview Report all family names have been changed to provide a level of anonymity.

1.2 Summary of Circumstances Leading to the Review

1.2.1 At about 6.25 on the morning of Saturday 17th March 2012, an ambulance was called to Kieran Lloyd's home because he was reported to have been found cold and unresponsive in his cot by his parents.

1.2.2 The paramedics attempted resuscitation and transported Kieran to the Accident and Emergency Department Northampton General Hospital where, despite further attempts at resuscitation, he was pronounced dead at 7.09am.

1.2.3 It was noted by medical staff that Kieran had bruising on his abdomen and on both knees. This bruising was confirmed as being present prior to resuscitation attempts. The parents were asked about the origin of the bruising and they claimed that they had already taken Kieran to their GP who had given an opinion that they were

abnormal blood vessels. This explanation, or another medical cause, was considered likely by a doctor at NGH but he also suggested that a non accidental cause remained a possibility.

1.2.4 Post mortem X Rays and examination of Kieran by Forensic and Paediatric Pathologists later revealed the presence of recent blunt trauma injuries to his head, abdomen, back and limbs. Internal examination revealed a significant head injury caused no more than 5 hours before his death, rib fractures of differing age and blunt force injuries to all four of his limbs. The pathologist suggested that the head injury was the likely cause of death.

1.2.5 During the period when Kieran was being treated in the Accident and Emergency Department, the police were called and a Detective Sergeant attended as the lead investigator. There was some tension and a breakdown in communication between the police and medical professionals during the 'rapid response' phase and a significant gap in time between the death being confirmed and X Rays being undertaken to reveal the full extent of Kieran's injuries. It soon became apparent that the GP denied ever seeing any bruising on Kieran or diagnosing abnormal blood vessels.

1.2.6 Kieran's parents were later arrested by the police on suspicion of his murder and both denied any wrongdoing. A Serious Case Review is not concerned with establishing culpability but the analysis in this Overview Report is underpinned by a belief that Kieran's injuries were deliberately inflicted by someone responsible for his care.

1.2.7 This Overview Report will describe what the serious case review revealed about a failure to take into account the troubled background of the parents when providing universal services, difficulties in respect of inter-agency communication and challenge, a lack of professional judgement and under-resourcing in respect of key medical diagnostic services which led to a failure to quickly identify and respond to significant injuries suffered by Kieran. It will identify some good practice by agencies and professionals, and offer recommendations for action to improve the services offered to children and families.

2. Process of the Review

2.0.1 Northamptonshire Safeguarding Children Board (LSCBN) has established a Serious Case Review Committee with responsibility for ensuring that LSCBN undertakes Serious Case Reviews in accordance with government guidance set out in Chapter 8 of *Working Together to Safeguard Children*. Their function is also to review cases of concern and advise the LSCB Independent Chair of the potential need to conduct a Serious Case Review. The Independent Chair will sign off any review and the Serious Case Review Committee will take responsibility for coordinating and monitoring multi agency arrangements for undertaking and publishing SCRs, and for monitoring the progress of the Action Plan resulting from such a review.

2.0.2 This case was referred to the Serious Case Review Committee on 21st March 2012 by the Child Death Review Panel. Initial information requests were sent to all agencies and this information was discussed alongside the referral form at the Serious Case Review Committee on 5th April 2012. The committee also heard information regarding the police investigation into the deaths and that the parents had been arrested. The committee felt that the case met the criteria for a mandatory SCR as set out in Chapter 8 of *Working Together to Safeguard Children* (2010).

2.0.3 A formal recommendation for Serious Case Review was made to the LSCBN Independent Chair on 10th April 2012 and her decision to conduct a Serious Case Review was made on 11th April 2012 and was notified to Ofsted and DFE on the same day.

2.0.4 Two independent people were identified and commissioned to lead the review (see below). The first meeting between those people and representatives from the LSCB took place on 27th April 2012 when draft Terms of Reference and appropriate membership for the SCR Panel were considered. An IMR Authors briefing day was held on 11th May 2012 and the first full SCR Panel meeting was convened on 22nd June 2012.

2.0.5 The Independent Panel Chair expressed general contentment with the process of the SCR although was concerned that the shortfall in Named GP capacity in Northamptonshire led to the Panel not

having specific expertise in medical general practice. Reports about the role the GP had in the care of Kieran were available to the Panel and Independent Author.

2.1 The Statutory Basis for Conducting a Serious Case Review

2.1.1 The role and function of a Local Safeguarding Children Board is set out in law by *The Local Safeguarding Children Board Regulations 2006, Statutory Instrument 2006/90*. Regulation 5 requires the LSCB to undertake a review where –

(a) abuse or neglect of a child is known or suspected; and

(b) either –

(i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

2.1.2 This process is known as a Serious Case Review, and the procedures for carrying out the review are prescribed in Chapter 8 of the statutory Government guidance, *Working Together to Safeguard Children (2010)*. The product of the Review, known as the Overview Report, is sent to the Secretary of State for Children, and scrutinised by DfE officials. All reviews of cases meeting the SCR criteria must result in a report which is published.

2.1.3 Revised *Statutory Guidance on Learning and Improvement* published by the Department for Education as a consultation draft in June 2012, prescribes that SCR reports should be written with publication in mind and should not contain personal information relating to surviving children, family members or others. This includes detailed chronologies, family histories, genograms, or information known to organisations about the child and family members. This Serious Case Review was commenced in March 2012 and therefore the draft guidance was not applicable, however, where possible this Overview Report has been prepared within the spirit suggested and, whilst ensuring any lessons are learnt, every effort has been made to minimise distress for family members. Personal

information about life within this family has been kept to the minimum required to provide a thorough and meaningful report into this review, although my analysis of practice benefited from a great deal of more detailed information contained within the Individual Management Review reports, which are listed below.

2.1.4 The purpose of the SCR procedure is to

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;

- identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and

- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

2.2 Independence

2.2.1 To ensure transparency, and to enhance public and family confidence in the process, The LSCB Chair appointed two independent people to lead the Serious Case Review.

2.2.2 In his document *Protection of Children in England: A Progress Report* Lord Laming (2009) expressed the view that in carrying out a Serious Case Review, it is important that the chairing and writing arrangements offer adequate scrutiny and challenge to all the agencies in a local area. For this reason, the chair of an SCR panel must be independent of all of those local agencies that were, or potentially could have been, involved in the case.

Mr. Kevin Harrington, JP, BA, MSc – Independent SCR Panel Chair

2.2.3 Mr Harrington was appointed to chair the Serious Case Review Panel formed to oversee and manage the review process in this case. He was the lead person for ensuring a robust and transparent review was carried out within each relevant agency, and for ensuring that

the business management plan and timescales were strictly adhered to.

2.2.4 He has had no involvement directly or indirectly with the child or any members of the families concerned or the services delivered by any of the agencies.

2.2.5 Mr. Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public and voluntary sectors.

2.2.6 He has a particular interest in the conduct of Serious Case Reviews, in respect of children and vulnerable adults and has worked on over 30 Serious Case Reviews, both providing independent leadership for Reviews and writing Review reports. He has written three recent reports which have been evaluated by Ofsted as "outstanding".

2.2.7 Mr. Harrington is extensively involved in professional regulatory work. He sits as Fitness to Practice Panelist for the General Medical Council and for the Nursing and Midwifery Council. He has worked as an Associate to the Parliamentary & Health Services Ombudsman. He has also served as a magistrate in the criminal courts in East London for over 15 years.

Dr. John Fox, MSc, PhD – Independent Overview Report Author

2.2.8 The *Working Together* (2010) guidance requires that:

- The LSCB should commission an overview report which brings together and analyses the findings of the various reports from agencies and others, and which makes recommendations for future action.

- The author of the overview report should be involved from an early stage and should have appropriate qualifications, knowledge or experience.

2.2.9 Dr Fox was responsible for drawing together all elements of the individual agency reviews, and for obtaining as much relevant information as possible from family members and significant others who might provide useful learning. He was responsible for analysing the professional practice of professionals and organisations and making recommendations to the LSCB for further action to better safeguard children.

2.2.10 He has had no involvement directly or indirectly with the child or any members of the families concerned or the services delivered by any of the agencies.

2.2.11 Dr Fox was a police officer for 31 years including 8 years as a Detective Superintendent and Head of Child Abuse Investigation in the Hampshire Police. He sat as a member of 4 LSCBs and was Vice Chair of Hampshire ACPC.

2.2.12 He represented the Association of Chief Police Officers on various Government working parties and committees, concerning child abuse and related issues, including the drafting of the *Working Together to Safeguard Children* documents (1999, 2006, and 2012) and *Achieving Best Evidence in Criminal Proceedings*, and had the ACPO lead portfolio role for Childhood Death and Forensic Pathology. He was appointed as the Police Service representative to Baroness Helena Kennedy's Intercollegiate Working Group on childhood death and was Lord Laming's police advisor and assessor, on the Victoria Climbie Inquiry.

2.2.13 He has previously chaired Serious Case Review Panels, and is regularly commissioned as Overview Report Author by LSCB's. During the period when Ofsted were evaluating SCR's, all his reports were graded as outstanding or good. In 2009 he conducted secondary evaluations, and provided reports as Independent Author, concerning 4 Serious Case Reviews that had earlier been considered inadequate by Ofsted and the Welsh Assembly Government.

2.3 Individual Management Reviews

2.3.1 "The aim of agency reviews should be to look openly and critically at individual and organisational practice to see whether the case indicates that improvements could and should be made, and if

so, to identify how those changes will be brought about." (Working Together to Safeguard Children 2010)

2.3.2 The Government guidance requires that those conducting agency reviews of individual services should not have been directly concerned with the child or family, or given professional advice on the case, or be the immediate line manager of the practitioner(s) involved.

2.3.3 The people conducting the individual agency IMRs for this Review were all approved by the Serious Case Review Panel and the Independent Author, as being senior personnel within each agency who were completely independent of any involvement or line management responsibilities concerning the case. On 11th May 2012, the IMR Report Authors were offered a briefing as to their responsibilities by the Overview Report Author and SCR Panel Chair, but only the representatives from the Police and NGH attended.

2.3.4 For those IMR Report Authors who did not attend the briefing event, the LSCBN Business Manager, offered to undertake individual sessions on 25th May 2012 with any IMR author who wish to discuss the IMR process, and to ascertain any support they wished to receive from the LSCBN Business Office.

2.3.5 The Serious Case Review Panel decided that the following agencies and organisations would be asked to contribute to the learning of this Review.

Individual Management Report provided by:
Northampton General Hospital NHS Trust
Northamptonshire PCT (GP Services)
Northamptonshire Police
NHS Northamptonshire (Health Overview Report)

Factual Report provided by:
East Midlands Ambulance Service
Connexions Northamptonshire
Education
Housing Services
Northamptonshire Probation

2.3.6 The LSCB provided each IMR report author with a template to assist in the writing of their reports, and this was successful in achieving standardisation and consistency, as well as ensuring that the reports focussed on the areas required by the Terms of Reference. Each IMR Author was invited to present their report to the SCR Panel where any clarification was provided, or additional work requested. In addition to this, where necessary I had direct contact with members of the IMR Team in order to best inform my analysis in this Overview Report.

2.3.7 It was noted by Ofsted (2010) that the duties of the Overview Report Author, include, 'challenging the quality and content of individual management reviews and ensuring that the overview report compensates for any identified deficiencies.' Collectively, the quality of the IMR Reports was sufficient for me to understand the case and provide an analysis of most of the issues I felt were significant.

Northampton General Hospital NHS Trust

2.3.8 This is a comprehensive IMR Report written by the Named Midwife for Safeguarding Children and Vulnerable Women, supported by the Named Nurse Safeguarding children

2.3.9 The methodology consisted of an in depth examination of all available medical records, although the parent held post natal notes

were missing and therefore not available to the IMR Report Author. The methodology also included face to face or telephone interviews with 11 key members of staff including midwives and consultant paediatricians. It is recognised that such interviews can be useful in understanding the pressures, mindset and feelings of the people involved in the case management.

2.3.10 This IMR Report was rich in data and contained an appropriate challenge and transparent analysis of the problems revealed during the review. The IMR Report highlights some good practice and makes several recommendations for improvement to services for children and families. The report gave me sufficient information and analysis to gain a full understanding of the learning within the NGH.

Northamptonshire Police

2.3.11 This was a comprehensive police IMR Report and it deserves favourable comment because the issues in question were unusual for the Reviewer in the sense that the police had not been involved in a traditional safeguarding/child protection role in respect of Kieran, but rather the IMR was primarily required to look at the post incident 'rapid response' procedures as well as various non-safeguarding related calls to Kieran's home. The individual management review was carried out by a Detective Inspector who is employed by Northamptonshire Police.

2.3.12 The methodology included interviews with two officers who were involved with the family, and the IMR was informed by a comprehensive examination by a police analyst of police databases and files within the agency. The Reviewer also obtained a considerable amount of information from the murder investigation team and therefore was able to bring extra knowledge to those conducting the SCR.

2.3.13 The Police IMR Report makes two recommendations designed to improve the service to children and families.

General Practice – Commissioned by Northamptonshire PCT

2.3.14 The IMR in respect of GP services was carried out by an experienced General Practitioner, the Named GP for Child Protection

within the Trust. The methodology included examining the medical notes of each patient and interviews with a GP, the Practice Manager, and the Practice Nurse.

2.3.15 The resulting report provides rich information about the provision of universal services to Kieran and his family. There is a clear description of all earlier health issues concerning his parents and generally the report was adequate for me to understand the GP involvement with the family and the implications of any medical conditions.

2.3.16 It was of concern that the IMR Report was submitted late and the IMR Report Author was unable to attend the IMR Authors briefing day (but did attend a briefing session with the LSCBN Business Manager). The Named GP was also unable to attend the SCR Panel meeting due to involvement in Safeguarding Children work and had agreed with the Designated Professionals that they would present the report to the Panel. At the time there was a lack of Named GP resource in Northamptonshire which impacted on the ability of the Named GP to respond to the various demands of SCRs and training of GPs. A particular request was also made for this IMR Author to have a conversation with the Pathologist to assist the analysis into aging of injuries and what might reasonably have been discovered by professionals during Kieran's life. The request to contact the pathologist was addressed in communications by the Designated Doctor which was considered by the health delegates to be a more appropriate response to the request. The conversation did not take place, but not because of a failure to act by the GP but as the issue was to be addressed by the Designated Doctor. Regrettably, this left a significant gap in the analysis of GP and HV services to the family. Because there was a direct contradiction between the mother's version of events and that of the family GP the provision of primary health care was of pivotal interest to those conducting the SCR. The lack of capacity for Named GPs in Northamptonshire was of concern to the SCR Panel and the reasons for this should be explored by the LSCB to ensure that any future SCR's are not disadvantaged by such a lack of engagement. **RECOMMENDATION 6**

2.3.17 Good practice was identified in respect of the family GP and the report makes two recommendations concerning the recording and sharing of information.

Health Overview Report

2.3.18 This comprehensive report was prepared by the Designated Nurse for Safeguarding Children, NHS Milton Keynes & Northamptonshire Cluster PCT.

2.3.19 NHS Milton Keynes & Northamptonshire PCT Cluster is the commissioner with responsibility for ensuring that the Northamptonshire population receives high quality health services. The report provides information and analysis in respect of the health care providers directly involved in the care of Kieran. The report helpfully draws together all the strands from the health related IMR Reports and factual summaries, it contained robust analysis and it gave me great assistance in respect of understanding the case and health agency involvement.

2.3.20 The report highlights 'less than expected practice' in terms of some record keeping within NGH and the Health Visiting Service as well as a need for better interagency cooperation between health and police. The report also concluded that there is significant learning to be had across all health agencies in protecting and safeguarding non mobile infants from harm, and it offers several useful learning areas.

2.4 The SCR Panel

2.4.1 The dedicated Serious Case Review Panel met 4 times prior to the presentation of the Overview Report. The Independent Chair robustly encouraged adherence to timescales, although not all IMR reports were returned by the deadline set by the Panel and this created the necessity to extend the timescale of the overall SCR. The general management of the SCR Panel meetings was efficient and effective. However, it was felt by the SCR Panel Chair that there was insufficient representation from different aspects of the health economy as well as the voluntary sector and education. It is highly regrettable that the NHS Northamptonshire's representative failed to engage completely because the service provided to Kieran's family by their GP was an issue of great importance within this Review.

2.4.2 The Independent Chair was assisted by the LSCBN Standards, Research & Development Manager as well as an administrative support officer at most meetings.

2.4.3 I was invited to attend the meetings of the SCR Panel. The Panel provided me with good advice and constructive comments about this Report and they were effective in ensuring most IMR Reports were as full and robust as possible.

2.4.4 Panel membership was as follows:

Kevin Harrington	Independent Chair of Serious Case Review Panel
El Dora Barnett	Children's Services Manager, NSPCC
Steve Lingley	Detective Chief Inspector, Northamptonshire Police
Cathy Sheehan	Designated Nurse for Safeguarding Children, NHS Northamptonshire
Jo Taylor-Palmer	Head of Integrated Safeguarding and Quality Assurance Services
Beverley Czyz	Business Manager, LSCBN

2.5 Terms of Reference

2.5.1 The review covered the period from 1st June 2011, when Kieran's mother was believed to be first in contact with services about her pregnancy, up to and including the post mortem examination on 20th March 2012.

2.5.2 The full Terms of Reference (ToR) can be found at Appendix A.

2.5.3 The ToR were ratified by the LSCBN Independent Chair on 10th May 2012, and thereafter became the instructions to the two independent people about the scope required for the Review.

2.5.4 The ToR specified 6 key issues in this case together with a requirement that these issues *'require particular analysis'* within the Overview Reports.

2.6 The Voice of the Children, Family and Significant Others

2.6.1 A commitment to providing the fullest opportunity for individuals with a close connection to the family to be invited to participate in the reviews was agreed at the first panel meeting. It was agreed that Kierans' mother, father, and maternal grandfather should be approached.

2.6.2 The SCR Panel Chair wrote to the family members on 20th April 2012 offering a meeting to explain the process of reviews and making it clear that they would be welcome to contribute to the learning. The letter was jargon-free and as non-businesslike in tone as possible. The letter was hand-delivered by a representative from the SCR Panel who visited the family at home on Tuesday 8th May 2012 who used the opportunity to explain the scope and purpose of the review, but Kieran's mother was not feeling well enough to consider all the information. The Panel representative also spoke with Kieran's maternal grandfather on two occasions and she visited the parents again on Wednesday 16th May to see if they had any further questions and to seek consent to access their medical records.

2.6.3 As discussed earlier, there is a parallel police homicide investigation into the death of Kieran. In accordance with Paragraph 8.25 *Working Together to Safeguard Children* (2010) the Overview Report Author made contact with the police Senior Investigating Officer (SIO) to discuss whether and how the SCR process might have a bearing on his investigation. It was explained to the SIO that the intention was to seek a contribution from the parents by way of a formal discussion. After obtaining a view from the Crown Prosecution Service the SIO raised no objection, subject to certain safeguards which the Overview Report Author was happy to comply with.

2.6.4 An arrangement was made for the Overview Report Author and another Panel member to meet both Kieran's parents at a local health centre on 27th July 2012 in order to seek a contribution to the learning for the SCR. Despite their initial agreement to attend the

meeting, Kieran's mother sent a message shortly before it was due to start to say that they would be unable to make it. Further attempts were made to offer the family the chance to contribute to the learning but in the end these were unsuccessful and it is regrettable that the voice of the family is not available to assist the learning.

2.6.5 It is noteworthy that despite the fact that both parents had been arrested and were on police bail, the SIO was extremely helpful in supporting the needs of this Review. As described above he was contacted by the Independent Overview Report Author and asked for his view as to the timing of any conversations with the parents and after a discussion with the Crown Prosecution Service he wrote back agreeing to the meeting with the parents subject to a request for access to any notes from the conversations. The SIO also provided the SCR with some valuable information gathered during the homicide investigation such as evidence from a family friend suggesting that Kieran's mother may have been the victim of domestic abuse. As will be later explained this is relevant to the overall analysis of practice because health professionals failed to explore this aspect of her life during pregnancy and at the time of the birth. In general terms, this was a very good example of how a Serious Case Review and parallel criminal proceedings can operate alongside each other in a mutually beneficial way.

2.7 Individual Needs

2.7.1 The guidance in *Working Together to Safeguard Children* requires consideration to be given to individual needs - racial, cultural, linguistic and religious identity – of the child who is the subject of a Serious Case Review.

2.7.2 Kieran and his parents are white British and there is no information within any case files that the family had any religious beliefs. There was no evidence in the material that any issues of race, religion, language or culture affected events in this case or should have been significant in influencing the practice or approach taken to the delivery of services.

2.7.3 There is evidence of poverty within the household, and specifically, in December 2011, Kieran's mother applied for housing and council tax benefit. It is not believed that either Ben Lloyd or

Kelly Quinn had a regular full or part time job and Ben Lloyd had previously served a prison sentence for assault (before Kieran was born). At the time of Kieran's death, Ben Lloyd was on bail for an offence of burglary, which meant he had an electronic monitoring tag and was on a 7pm to 7am curfew to remain indoors.

2.7.4 There were comments made in the medical notes that Kieran's mother had support from her extended family which suggests that she was continuing along her cultural normal pattern of social integration. There is no evidence in education or health records to suggest that this family experienced social or any other form of exclusion and this may have been disarming to professionals, but whilst there was no overt presentation of classic deprivation or signs of neglect within the family there were other more subtle features, as described above, which could, if recognised, have raised concern.

2.8 Accountability for the Overview Report

2.8.1 I have attended all the meetings of the SCR Panel and the briefing day arranged for the IMR Report Authors.

2.8.2 Whereas I am accountable for the content and analysis within this Overview Report, the members of the SCR Panel have contributed to the process of the preparation and have offered helpful comments and suggestions during the drafting process.

2.8.3 The Independent SCR Panel Chair and the SCR Panel have fully endorsed the content of this report.

3. The Facts - Summary of agency involvement

Source

This section is designed to summarise the key relevant information that was known to the agencies and professionals involved about the parents, and the circumstances of the children.

3.1 Kelly Quinn's early years

3.1.1 Kelly Quinn was born in 1992. Little is known about her very early childhood.

GP Records

3.1.2 On 23rd March 2004, Kelly Quinn disclosed that she had suffered serious harm perpetrated by the ex-partner of an older family member. The GP records indicate that the incident happened in 2002 when Kelly was 10 years old. The police took no further action over this because Kelly *'did not make a formal complaint*.' This is indicative of a troubled childhood.

Police records

GP Records

3.1.3 In 2002, GP records report that Kelly Quinn had above average marks in SATS, and was doing well in school. However there is also evidence of a troubled childhood.

GP Records

3.1.4 In 2006, when Kelly was 14 years old she was taken to the GP by her mother requesting tablets to "calm her down". She was thought to be suffering Post-Traumatic-Stress-Disorder relating to a nieces' limb amputations. Her older brother was in prison for drugs related offences, and Kelly had a history of aggressive behaviour at school where it was reported she had hit a child and been abusive to teachers. She had seen psychologists twice at the hospital by now and it was not thought to be helping her, and had been discharged. She was referred to Child and Family Guidance services.

GP Records

3.1.5 In October 2006 Kelly Quinn was waiting for counselling and was at this point excluded from school for being "non compliant" and having difficulty controlling her temper. This apparent aggressive nature is further evidenced because in 2006 Kelly Quinn received an informal action for common assault after hitting a fellow student at School. In 2009 she received a reprimand for actual bodily harm after attacking a girl in the street, by punching her several times in the head and face causing

GP Records

Police IMR

two black eyes and a cut nose.

3.1.6 In 2007 Kelly was discharged from CAMHS with a letter stating that she had made good progress. GP Records

3.1.7 On the 9th June 2008 Kelly Quinn was video interviewed by a police officer and social worker in relation to an allegation of inappropriate touching by school caretaker. No further action was taken by the police. Kelly had completed her exams and was no longer attending the school. Additional social care support was offered to her and her family but this was declined. This was Kelly's only involvement with Children's Social Care. CSC Factual Report

3.1.8 According to police records, Kelly Quinn and Ben Lloyd began their relationship between 2-3 years ago. Police IMR

3.2 Ben Lloyd's early years

3.2.1 Ben Lloyd was born in 1989. There is evidence that in his first few years of life he experienced tension at home because he was placed on the child protection register from 27/7/1991 to 01/1/1992 for emotional and physical abuse. There are three child protection referrals on the Northamptonshire Police Referral Systems which relate to Ben Lloyd and his brothers being out of control and in 1994 the police investigated his mother who reportedly slapped Ben's sibling across the face causing bruising and red marks. Ben's mother stated that she couldn't cope with his sibling anymore. Police IMR

CSC Factual Report

Education notes

3.2.2 In May 1999 an Initial Assessment was carried out following a report to Police that Ben Lloyd had been assaulted by his mother. The incident related to him hitting his eye on the corner of a chair as he 'ducked' when his mother tried to slap him. CSC Factual Report

3.2.3 On 11th March 2002, when Ben Lloyd was 13, the police received an anonymous call expressing concerns over his behaviour, going missing etc. At around this time, Ben Lloyd was referred for a CAMHS review with 'ADHD characteristics' but it was decided that he did not fulfil all the criteria. Children's Social Care records indicate that in April 2002 Ben Lloyd and his brother were both diagnosed as suffering with a form of Autism, and their Police IMR

GP Records

Education notes

parent was unable to cope and required support. (There is no mention of 'Autism' in medical records.

Police IMR

3.2.4 In 2003, a neighbour called police with concerns for Ben Lloyd and his siblings, stating she believes his mother cannot control her children and they are always getting into trouble, and she does not believe they attend school. This information is corroborated by GP notes which record *"Apparently [Ben Lloyd] had no schooling for 2 years from 2002 to 2004"*

GP Records

3.2.5 In 2005, feedback from CAMHS about Ben Lloyd revealed "considerable social and family disruption, the impact of which should not be underestimated".

GP Records

3.2.6 Between 2007 and the relevant period for this review, it is recorded in police systems that Ben Lloyd had a number of convictions and arrests ranging from serious acquisitive crime to violent offences. In one of these incidents, Ben Lloyd is alleged to have assaulted the pregnant ex-girlfriend of his cousin, which may have caused her to lose the baby. Ben Lloyd served a short prison sentence and police recorded in 2009 that he *'has been drinking a large amount since his release from prison.'*

Police IMR

3.2.7 Ben LLOYD was again released from prison on 23rd March 2011 and a month later attended a meeting with police during which he mentioned that his girlfriend that Kelly QUINN is pregnant. He stated he was happy but apprehensive. and acknowledged that he needs to be more motivated to get work in light of the pregnancy.

Police IMR

3.3 The Relevant Period of the Review

3.3.1 On 16th June 2011, Kelly Quinn together with a friend, attended a routine pregnancy booking visit at her GP surgery where she was seen by a community midwife. She was revealed to be 9 weeks pregnant at this time. A full social and medical history and risk assessment was completed by the midwife. The question regarding domestic abuse was not asked as the friend was present. Kelly disclosed that she smoked and had previously engaged in alcohol binge drinking, but not since she knew she was pregnant. She confirmed that Ben Lloyd was the father of the

NGH Medical records

baby and that she was staying with a friend due to her mother not knowing about pregnancy.

3.3.2 On 2nd August 2011, Kelly Quinn failed to attend an appointment with a Consultant Obstetrician at the NGH antenatal clinic. This information was passed to the GP with a request that the midwife follow up the non attendance, However, the information was not shared from GP surgery to community midwife. NGH Medical records

3.3.3 On 29th September 2011, Kelly Quinn attended a routine antenatal visit at GP surgery with community midwife 1 at 26 weeks of pregnancy. All investigations were reported to be within normal limits. NGH Medical records

3.3.4 In approximately October 2011, Kelly Quinn was visited by a friend who observed possible signs of domestic violence. There is no evidence that this was reported to agencies at the time but was revealed during a police interview for the subsequent homicide investigation. The friend noted, *'Kelly was around six or seven months pregnant at the time, when I got there Kelly was in her pyjamas. I noticed that she had a bruise and possibly a cut above her left eye. She told me that there had been a row between Ben and Kelly, and Ben had hit her.'* Kelly's next appointment with the Community Midwife took place on 18th October 2011 but no injuries were noted at that time and the Midwife had *'no concerns about her wellbeing.'* Police IMR NGH Medical records

3.3.5 On 11th November 2011, Kelly Quinn contacted Northampton Borough Council to make a housing application. She was given a homeless application appointment which she failed to attend but then on 15th December 2011 she again contacted the council to make an application for housing benefit. She stated that she was intending to live in privately rented accommodation. Police records show that In December 2011, Kelly Quinn and Ben Lloyd moved to privately rented accommodation, which is a single bedroom first floor flat. They are the sole occupants. NBC Factual Report Police IMR

3.3.6 **In late January 2012, Kieran Lloyd was born at Northampton General Hospital.** The birth was uncomplicated and Ben Lloyd and Kelly's grandmother were also present for NGH Medical records

support. Kieran's birth weight was recorded as being between the 10th and 50th centile and this was considered to be of a good birth weight and therefore of no concern. A routine examination of Kieran following delivery showed no abnormalities, in fact based upon the Apgar score (which is a system that is used to evaluate a new born baby's condition at birth) Kieran's condition was assessed as good. Kieran was born at 10am and 12 hours later Kelly discharged herself from hospital against medical advice. A 'self discharge form' was not completed correctly for Kelly, and a copy was not sent to GP surgery.

3.3.7 The following day a routine postnatal visit by a midwife was conducted at the flat where Kieran and his mother were now living. On arrival the midwife met Kelly, who was sitting on the sofa feeding Kieran. Ben Lloyd was also present. The visit was described in the medical notes as *'non-eventful, the flat was clean and tidy and baby was clean and well fed, good contact between mother and baby during feeding'.* The midwife had *'no concerns'.*

NGH Medical records

3.3.8 At around the end of January 2012, the case was transferred from the midwife to a health visitor. Medical records reveal that this handover did not take place correctly but nevertheless a student health visitor did see Kieran at home on 1st February 2012. The baby was examined and no abnormalities noted. There is no recorded evidence that the HV student discussed the case with her mentor during post visit supervision, although the student reports that this discussion occurred.

NGH Medical records

3.3.9 On 3rd February 2012 police records indicate the Ben Lloyds older brother would be released from prison on 21st February 2012 and planned to reside at the one bedroom flat occupied by Kieran and his parents.

Police IMR

3.3.10 On 8th February 2012, the student health visitor again saw Kieran for a routine visit at his home. Kieran's mother and father were both present. Nothing untoward was noted. There is no recorded evidence that the HV student discussed the case with her mentor during post visit supervision, although the student reports that this discussion occurred.

NHFT Records

3.3.11 On 29th February a police report states that 'there is a lot

Police IMR

of noise coming from flat of Ben LLOYD and Kelly QUINN late evening and into the early hours of the morning.' **Kieran was 6 weeks old at this time.**

3.3.12 On 7th March 2012, the student health visitor saw Kieran again for a routine check. The visit took place at his home and his mother and father were present. Medical records reveal, *'six week review sheet shows physical examination completed as satisfactory. Reaching expected developmental milestones. No parental concerns voiced. No signs of postnatal depression noted.'* There is no recorded evidence that the HV student discussed the case with her mentor during post visit supervision, although the student reports that this discussion occurred.

NHFT Records

3.3.13 On 12th March 2012, police went to Kieran's home and arrested his father on suspicion of burglary. The police officer who conducted the search noticed Kieran in a pram in the hallway The officer *'only took a quick glimpse of the baby as she moved around the pram'*. She stated the property appeared clean and safe and she had no concerns about the welfare of the child. It was also noted that Ben Lloyd's brother had now left the household after a dispute with Kelly. Earlier police intelligence revealed that the brother had been seen by a neighbour with a substance which was possibly cocaine, and police were also notified by a neighbour about a smell of cannabis coming from Kieran's home. As a result of the burglary arrest, Ben Lloyd was bailed with a curfew to be indoors between 7pm and 7am.

Police IMR

3.3.14 At 0630 on 17th March 2012, Kieran was brought into the Accident and Emergency Department at Northampton General Hospital by paramedics due to 'paediatric arrest'. He failed to respond to resuscitation and was pronounced dead at 0709hours. **Kieran was 8 weeks old.**

NGH Medical records

4. A Day in the Life of Kieran and his Family

4.01 The family lived in a privately rented, one bedroom flat. For some of Kieran's life, the flat was also occupied by his uncle, Kevin Lloyd. Kieran slept in a Moses basket in the same room as his parents who shared a mattress on the floor. When a police officer visited the flat to conduct a search a week before Kieran died, she described it as being *'in very good order'*.

4.02 There is evidence that drugs such as cannabis and cocaine were used by the adults in the household. When interviewed by police after his death, Ben Lloyd and Kelly Quinn stated they had consumed some alcohol – namely cans of Stella lager. Kelly stated she had one and a half cans and Ben had two. They also told police they smoked some cannabis. Throughout the evening they had watched television and played a FIFA football game.

4.03 Kelly Quinn and Ben Lloyd told police they had recently moved their mattress into the lounge where they sleep on the floor. The Moses basket in which Kieran slept was positioned to the left of the door, close to the mattress. The family moved into this room in order to watch television.

4.04 Neighbours have said that there was a lot of noise coming from Kieran's flat and that they have complained to their landlord and the council regarding this. They have said that the communal door is constantly opened and shut late at night and into the early hours of the morning.

4.05 It appears that a day in the life of Kieran consisted of sleeping in a pram or Moses basket in a noisy, chaotic, smoke filled environment. Due to his age, Kieran relied entirely on his parents for stimulation and care but it is not known how much attention or how much stimulation he was given during the day, although health records indicate that *'the baby was seen to be well fed, clean and bonding with his mother'*. Since smoking, including cannabis use was taking place in the room occupied by Kieran it is likely that he would have been subjected to the chemical by-product of that activity.

4.06 The Post Mortem report confirms that during his life Kieran suffered several injuries including rib fractures of differing age, and these must have been caused deliberately. That he died from a violent assault is the primary investigative hypothesis of the senior investigating police officer, yet the pathologist's evidence suggests that Kieran was injured on several other occasions before the final incident, and it is therefore likely that he was suffering intense pain for a considerable period of his life.

5. Analysis of Practice and the Lessons Learnt

5.0.1 Issues which have been identified as requiring particular analysis in respect of the circumstances of this case are:

- What relevant historical information prior to Kieran's birth was known to the agencies about the background and experiences of Kieran's parents? Were there any signs or indicators that Kieran may be at risk and that his parents might not be able to protect him from these risks?

- Were appropriate actions taken by agencies in response to any indicators that Kieran might be at risk of significant harm or vulnerable to becoming a child in need?

- Were the required knowledge, skills and experience regarding the identification of and response to child abuse available within agencies? Were there any gaps that may have impacted upon the outcomes for Kieran?

- Are there particular lessons arising from the interface between agencies? Should a referral have been made at any point to Children's Social Care Services?

- What consideration was given to the level of engagement of both the mother and father when assessing the needs and risk to the children?

- With hindsight what, if anything, could have been done differently and what impact, if any, such action may or may not have had on the outcomes for Kieran?

5.0.2 Each of these key issues is discussed later in this section but the headline result of the analysis of the available information is that this Serious Case Review has revealed no evidence that during his life any agency or individual expressed any specific concerns for Kieran's developmental milestones, health, wellbeing or upbringing. As a child he was 'visible' in the sense that he was seen appropriately by midwives, health visitors and his GP, as well as friends and family. There had been no safeguarding or 'child in need' referrals from any third party to children's social care and he had never come to the notice of the police. No injuries, signs of neglect or other concerns which could reasonably have necessitated a safeguarding referral to Children's Social Care were noticed or recorded by any professional. Whether any signs of injury to Kieran may have been missed is considered below.

5.0.3 The analysis by the Health Overview Report Author identified several areas where she felt practice was less than satisfactory, but no serious failures or errors of judgement by health professionals were identified.

5.0.4 The remainder of this analysis section will follow the case specific themes prescribed by the Terms of Reference and examine certain key elements on the day of Kieran's death, and then examine, in broad terms, whether there was any reasonable possibility that an agency or individual professional could or should have been able to predict that Kieran was a child in need of protection.

5.1 a) What relevant historical information prior to Kieran's birth was known to the agencies about the background and experiences of Kieran's parents? b) Were there any signs or indicators that Kieran may be at risk and that his parents might not be able to protect him from these risks?

5.1.1 Section 3 above confirms that although no significant concerns had ever been raised about the parenting capacity of Ben Lloyd or Kelly Quinn, there was quite a body of relevant information which might have led to a closer assessment when Kieran was born.

5.1.2 The Author of the GP IMR Report noted that the family GP held a historic body of evidence regarding both parents as adolescents,

some of which could be considered significant in terms of their likely success as parents. The IMR Report Author felt that had the issues identified in Kelly's past medical history been shared during pregnancy with community midwives, and following Kieran's birth had been passed onto HV services, this knowledge may have assisted professionals in better understanding Kelly's feelings regarding becoming a mother.

5.1.3 NGH had historical information on both parents as children and this was in their respective archived medical notes within the paediatric history. As, at the time there were no known or volunteered risks from the mother, the history was not accessed. NGH staff did not, as a matter of course, access the paternal notes and worryingly this is, according to a section of the NGH IMR Report, due to a perceived restriction imposed by data protection laws. However in other areas of the IMR Report it also states that if risk factors were identified then parental files would be reviewed.

5.1.4 It is important that midwives are clear about their ability to access notes so if there is a perception that they are not able to access paternal notes then this perception is wrong, and should be dispelled. NGHT staff can access paternal notes if necessary – with or without consent. The Data Protection Act is not relevant and any perception that this is a blockage to accessing the fathers' information should be of great concern to the LSCB and its constituent agencies.

5.1.5 In his 2009 report, Lord Laming firmly reminded us about the role of fathers within parenthood. He stressed, *'parenthood incorporates not only rights but also responsibilities: it is a lifetime commitment. Particular mention should be made of the part to be played by fathers.'* The spirit of this comment seems to be that with fatherhood should come an acceptance that one's own personal rights to privacy will be subordinate to the responsibility that one's child is properly safeguarded. This was also a theme recognised by Brandon et al (2009) in one of the Biennial Analysis Reports of Serious Case Reviews:

The failure to know about or take account of men in the household was also a theme in a number of serious case reviews. Assessments and support plans tended to focus on the mother's problems in caring for her children and paid little attention to the men in the household and the risks of harm they might pose to the children given histories of domestic violence or allegations of or convictions for sexual abuse.

Brandon et al, (2009)

5.1.6 Laming (2009) further pointed out that '*children can only be protected effectively when all agencies pool information, so that a full picture of the child's life is better understood*.' This sharing of information has long been a problem in a multi agency sense, but it is hard to believe that it should still present difficulties even within the closed domain of the Health Sector. Yet in this case information was not accessed or shared within that single agency, and part of the reason seems to be a misunderstanding of the data protection laws. '*Whilst the law rightly seeks to preserve individuals' privacy and confidentiality, it should not be used (and was never intended) as a barrier to appropriate information sharing between professionals. The safety and welfare of children is of paramount importance, and agencies may lawfully share confidential information about the child or the parent, without consent, if doing so is in the public interest*' (Laming, 2009). There is no need for a full blown child protection concern to allow information sharing between professionals; a '*public interest'* has been interpreted (Laming, 2009) as simply being '*the promotion of child welfare.'*

5.1.7 Despite information being available in agency files, there was a heavy reliance on information that was volunteered by the parents during routine appointments. The NGH IMR Report explains that maternal records are accessed on the GP IT system by the community midwife, but if past risk events have not been flagged by the GP or other members of the primary healthcare team, then the midwife would not be aware of them. The midwife relies on the details she obtains from the client in answering the routine questions, or any other area that may arise during the pregnancy and it is policy for midwives to treat only the mother (and not the father) as their

'client'. The midwife is therefore dependent on the mother's willingness to disclose information, which she may be reticent to share. Since the primary and most vulnerable client in any new birth is the baby, it seems unacceptable that the fullest information about his primary caregivers is not even accessed.

5.1.8 Data protection laws rarely, if ever, prevent professionals from accessing information which could help safeguard children, and it is concerning that in Northamptonshire, and perhaps elsewhere in England, this seems to be a systemic problem rather than a particular failure in this individual case. **RECOMMENDATIONS 4 & 5**

5.1.9 Had it been accessed, the information which was potentially available on each parent can be summarised thus:

Ben Lloyd

- He had a number of contacts with Children Services. In July 1991 he was placed on the Child Protection Register under the category of Emotional and Physical abuse.

- In May 1999 an Initial Assessment was carried out following a report to Police that he had been assaulted by his mother.

- 2002 CAMHS review - ADHD characteristics but does not fulfil all the criteria.

- 2004 Aged 15 Had issues relating to his schooling. GP notes state "Apparently had no schooling for 2 years from 2002 to 2004"

- 2004 Referred to the Child and Adolescent Mental Health Service (CAMHS)

- 2005 Feedback from CAMHS revealed "considerable social and family disruption, the impact of which should not be underestimated".

- 2009 Attended A&E with alcohol related issues and suspected overdose. He left before being fully assessed.

There was actually very little in the medical notes about Kieran's father after the 2005 discharge from CAMHS.

Kelly Quinn

- 2002 Allegedly sexually abused by sisters' partner – disclosed to CAMHS in 2004.

- 2003 Panic attacks, seen by psychology and advised of coping strategies and discharged.

- 2004 Referred by paediatrician for counselling following nieces limb amputations. She was originally referred to paediatricians for suspected epilepsy – which was discounted.

- 2006 Kieran's mother was brought to the GP by her own mother requesting tablets to "calm her down". She was thought to be suffering Post-Traumatic-Stress-Disorder relating to nieces amputations. Her older brother was in prison for drugs related offences, the GP commented upon the past history of alleged sexual abuse during a consultation. A history of aggressive behaviour at school was reported as she had hit a child and been abusive to teachers.

- 2006 October – she was waiting for counselling and was at this point excluded from school for being "non compliant" and having difficulty controlling her temper. She was again referred to psychology.

- 2006 GP reports that she was now back at school during a consultation for an unrelated issue.

- 2007 She was discharged from CAMHS with letter stating that she had made good progress.

5.1.10 Other environmental factors which may have been taken into account would include:

- The father appears not to have been present at most antenatal appointments and therefore little was known about him.

- The couple were given information about antenatal classes but chose not to attend.

- Kelly was a pregnant teenager aged 19 years at time of pregnancy and it was their first child

- The couple had only been living together for a short period.

5.1.11 This case reveals that formal communication between GPs and Midwives at the very beginning of pregnancy is not a routine aspect of GP care in Northamptonshire. This transfer of information between organisations is important as the information given to midwives is largely self declared and may not reflect the historical accumulation of knowledge about a patient. However, the view of the Author of the GP IMR Report is that it is unlikely that even if the markers of risk had been pointed out to the midwife that subsequent actions would have been any different. The duration of 6-7 years between the moderate markers of risk and the pregnancy is likely to have meant actions would not have changed professional's behaviour.

5.1.12 The sexual abuse suffered by Kelly during childhood was a significant risk factor in the context of determining her parenting ability. There is a body of evidence which suggests that child sexual abuse has long-term repercussions for adult mental health, parenting relationships, and child adjustment in the succeeding generation. *(Roberts et al, 2004)* The fact that Kelly had made an allegation of serious sexual abuse when aged 11 could have led to consideration that her own pregnancy might cause a revisit to the feelings she had at that time. This was a significant event in this young mother's life and should have at least triggered different lines of enquiry such as causing the Midwife to discuss with Kelly her feelings about pregnancy and childbirth.

5.2 Were appropriate actions taken by agencies in response to any indicators that Kieran might be at risk of significant harm or vulnerable to becoming a child in need?

5.2.1 Whereas there were no gross indicators that Kieran might be at risk of significant harm, this was not a 'run of the mill' family – indeed, in my view the information described at paragraph 5.1.5 above indicates that this was quite a risky family - and it is reasonable to suggest that community midwives or the GP should

have recognised that the parents may need additional support. It is not suggested that evidence was known which might reasonably have required an immediate referral to Children's Social Care, but there were sufficient concerns available which, had they been accessed and considered, could reasonably have been the trigger for the Common Assessment Framework (CAF).[1]

5.2.2 It is also the collective view of the SCR Panel that the level of risk and threshold indicators should have been considered against the Integrated Working Procedures. It was agreed that as a minimum a CAF should have been initiated.

5.2.3 It was considered by the SCR panel that the point where concerns should have been acted on was where Kieran's mother failed to attend maternity appointments. In the antenatal period Kelly 'Did Not Attend' 3 appointments and the Antenatal Clinic passed this information onto the Community Midwife via the GP surgery but it was unclear whether this had been passed onto the actual midwife working with Kelly. The antenatal tracker is used by the community midwives and is recorded at the GP surgery. It keeps a record of appointments and having identified that Kelly did not attend 3 appointments during her pregnancy this should have been considered a cause for concern, thereby triggering further enquiry such as at least reviewing Kelly and Ben's GP notes which would have revealed the concerning factors outlined above. This in turn might reasonably have led to a CAF being instigated.

5.2.4 During the appointments she did attend, when Kelly was spoken to by the midwife there is no record that the conversation took into account the fact she was a victim of serious sexual abuse when she was 11 years old. As this was Kelly's first pregnancy it should have been considered that such a traumatic and significant event in this young mother's life might trigger negative feelings towards pregnancy and motherhood generally. There is no evidence that any midwife providing a service to Kelly even knew about this

[1] The CAF was established by the former Department for Children, Schools and Families. It is described on their Every Child Matters website as *"a standardised approach to conducting assessments of children's additional needs and deciding how these should be met…The CAF promotes more effective, earlier identification of additional needs, particularly in universal services. It aims to provide a simple process for a holistic assessment of children's needs and strengths; taking account of the roles of parents, carers and environmental factors on their development"*

event because the GP notes were not reviewed during pregnancy. This is concerning in itself, but had the failed maternity appointments triggered a CAF as suggested above, different lines of enquiry may have resulted including seeking full access to all the information held by the GP and causing the midwife to discuss with Kelly what her feelings were about pregnancy and childbirth.

5.2.5 There was a further potential missed opportunity to gather relevant information about this family because as part of the 'booking appointment' there is an expectation placed upon the midwife to ask a question on domestic abuse, and this question should in fact be asked twice more during the course of the pregnancy. It is noted that in this case the domestic abuse question was not asked at the booking appointment by the community midwife due to a friend being present with Kelly. This reason was recorded in the notes but on the two subsequent occasions when the domestic abuse enquiry should have been made, the midwife apparently failed to ask the question and the reason why it was not re-visited during the pregnancy is not documented. This is considered by the Health Overview Report Author to be less than expected practice.

5.2.6 The reason this failure of good practice might have been highly relevant is that it is documented in the Police IMR Report that a friend of Kelly's reported that she had seen Kelly with bruising and that she was victim of at least one episode of domestic abuse perpetrated by Ben during her pregnancy. It is not of course certain that Kelly would have revealed to a midwife whether she was being abused within the home. Indeed, it is noted that later the Student HV allocated to the family asked a routine question about domestic abuse as part of her assessment and was told by Kieran's mother that it was not an issue. There is no reason to believe she would have volunteered a different response had the question been asked earlier by a midwife but nevertheless the question should have been asked so that she at least would have had the opportunity to do so.

5.2.7 The Family Assessment Tool (Version 4, December 2010) is a standardised system which enables every practitioner within Health Visiting and Children and Young Peoples Nursing to identify and manage the needs and potential risks within their caseload. It is considered by the SCR Panel that this assessment tool is inadequate because no questions are asked about the parents or their past

experiences. In the case of Kelly and Ben, their past experiences would have been very relevant to an assessment of the family. It is noted by the Health Overview Report that there is work being initiated to extend the FAT tool to midwifery services and to strengthen this tool in practice.

5.3 Are there particular lessons arising from the interface between agencies?

5.3.1 One of the key triggers for the commissioning of this serious case review was an apparent breakdown in interagency cooperation at the NGH between the lead clinician and the lead police investigator in the hours after Kieran's death. The police IMR Report describes how, *'The police officers were frustrated by the lack of cooperation from the Consultant Paediatrician'*. This part of the analysis section will examine the circumstances in detail and explore whether or not such frustration was justified but it will first be helpful to reflect on the background to the current national guidelines for the multi agency investigation of sudden unexpected death in children (SUDC).

5.3.2 When, in 2003, three high profile criminal convictions involving the prosecution of mothers for causing the deaths of their babies were overturned by the Court of Appeal, The Royal College of Pathologists and The Royal College of Paediatrics and Child Health asked Baroness Helena Kennedy QC to chair an intercollegiate Working Group to review how sudden deaths in infancy should be investigated. The subsequent report published in 2004, made several recommendations which were used by the Government to form the basis of the statutory guidance in Chapter 7, *Working Together to Safeguard Children* (2010) and which states a *'multi-professional approach is required to ensure collaboration among all involved'* (Para 7.65). Each LSCB was thereafter encouraged to produce a local protocol, based upon the statutory guidelines in *Working Together*, to enhance inter-agency co-operation in SUDC investigations. Northamptonshire LSCB produced such a protocol and it is known as the *LSCBN Child Death Review and Response Arrangements* (CDRA). This protocol was firmly embedded into the safeguarding training and fabric of the LSCB procedural material by the time Kieran died in March 2012. Northampton General Hospital and Northamptonshire Police have signed up to the CDRA and so employees working for both those agencies are expected to adhere to it.

5.3.3 The key issue which led to the *'frustration'* mentioned above is that in the immediate aftermath of Kieran's death, the lead police officer felt that he was reliant on the Consultant Paediatrician to declare the death as suspicious before he could decide whether to instigate a homicide investigation. It is suggested that the Consultant Paediatrician failed to give a firm view on the cause of the injuries and absented himself from the A&E Department refusing to return and discuss the case with the police lead investigator. Furthermore, a request by the police to carry out a full skeletal X Ray on Kieran's body was not undertaken by the NGH because they claimed the 'necessary expertise' was not available at the weekend. This apparent lack of availability of necessary expertise is discussed in more detail at paragraph 5.3.24 below.

5.3.4 The result of these factors is that it was not until after the Post Mortem examination three days later that the police fully accepted they were dealing with a homicide investigation and it is possible that vital evidence may have been lost as a result of the delay. Of greater concern in the wider safeguarding context, is that if Kieran had been a child with siblings, those other children may have been left at risk because the full picture of Kieran's death was not established at the earliest opportunity. Although it could be argued that in this particular case any failure in inter-agency co-operation made no difference to the outcome of the primary victim, in another case it might make a difference, which should be of concern to the LSCB. Indeed, it should also be considered that if Kieran's parents go on to have other children in the future, a flawed police investigation in this case might be detrimental to those assessing the family as to their suitability to care for such children. The questions for this review to consider therefore are as follows:

- Could the police have done more to establish better inter-agency co-operation on the day of Kieran's death?

- Was the Consultant Paediatrician acting reasonably in not meeting with the police in A&E to discuss the case and conduct a joint examination of the body?

- Did the police in fact have sufficient information to make a judgement about whether to instigate a homicide investigation?

- Was it reasonable for the NGH to fail to carry out a full skeletal survey to ascertain the full extent of Kieran's injuries?

5.3.5 In considering why the police investigation did not get off to a good start, the analysis in the Police IMR Report puts the ball firmly in the 'medical court' by stating, *'As there was no clear direction on the potential cause of the injuries, the Senior Investigation Officer was not in a position to treat this as a murder enquiry. All the investigating officers required was an opinion from Dr CP1, that the injuries were more likely to be non-accidental to allow them to start a murder investigation. As we were not in a position to challenge Dr CP1 or gain a second opinion, the murder investigation was delayed.'*

5.3.6 The Detective Sergeant who attended NGH was an experienced Child Protection Team supervisor, but despite his experience the analysis in the Police IMR Report indicated that although he disagreed with the initial assessment and opinion of the Consultant Paediatrician he did not know how to challenge this decision making or obtain a second opinion. The Detective Sergeant reportedly '*found it difficult to challenge a qualified Consultant Paediatrician's assessment, as they are the experts in the medical field*.'

> The 'respectful uncertainty' needed in work with families is also required in multi-agency working where challenge of other professionals' opinions or judgments may be necessary. An organisational climate which supports and encourages sustained professional challenge is essential if the difficult tasks of recognising and responding to harm to the child are to be more effective.
>
> Brandon et al (2009)

5.3.7 This phenomenon of police officers finding it difficult to challenge senior medical professionals is not new. In fact it featured prominently within the report into the death of Victoria Climbie (Laming, 2003) which included the recommendation, '*Training for child protection officers must equip them with the confidence to*

question the views of professionals in other agencies, including doctors, no matter how eminent those professionals appear to be.'

5.3.8 Despite this recommendation in the Climbie Report, the Police IMR indicates that the experienced Detective Sergeant involved in this case felt unable to challenge a Consultant Paediatrician. In the 2010 Serious Case Review concerning Child F the Overview Report also made a reference to a Northamptonshire police officer who, at a professionals meeting, *'felt unable to challenge the assumptions being made about a medical diagnosis'*. It is concerning that despite this the Police IMR Report reveals *'police officers have not received any multi-agency training to allow them to challenge other professionals.'* It might therefore be wise for the Force to urgently review the training for such officers to ensure it takes account of Recommendation 100 in the Victoria Climbie Report.

5.3.9 In the next section of this Overview Report, there is a discussion concerning the appropriate level of police officer who should be deployed in a case of unexpected childhood death, and in particular it will be fully explained that Baroness Kennedy and ACPO recommend that the appropriate rank for the hands-on police lead investigator in a SUDC case should be at least detective inspector level. It is possible that one of the reasons for this is that there is often a need for the police to interface with senior doctors and other medical personnel. Although the policy in Northamptonshire is that a Detective Inspector will be informed by telephone, (and indeed in the case in question this happened), there is perhaps no substitute for the physical presence at the hospital of a detective of that rank during the multi agency discussion phase of the enquiry.

5.3.10 It is clear that during the first few hours into the investigation into Kieran's death the policy of having a Detective Inspector available for consultation by telephone did not work and I find it surprising that given the difficulties experienced by the Detective Sergeant at NGH, the Detective Inspector did not decide to actually go to the hospital to get a grip of the case. There is evidence to suggest that in this case the Detective Sergeant was not given adequate supervisory support.

5.3.11 The *LSCBN Child Death Review and Response Arrangements* require that a consultant paediatrician should be present when a

SUDC case occurs, and this person becomes the '*Responsible Paediatrician'* for the duration of the critical event meaning that they act as the lead clinician and co-ordinate the multi agency rapid response. When Kieran was brought into NGH a Consultant Paediatrician (CP1) was correctly called by A&E and arrived from home at 7 am and undertook the Responsible Paediatrician Role. The NGH IMR Report Author is satisfied that the initial medical procedures in A&E were followed correctly, including the taking of tissue samples and sensitive interaction with Kieran's parents. The lead police investigator had not at that time arrived at A&E and by the time he did, the Consultant Paediatrician had left to go to a ward to carry out other work.

5.3.12 Health and police records both indicate that the first police officer arrived in A&E at 8.30 am which was an hour and a half after Kieran had been pronounced dead. On the face of it, this seems to be a fairly tardy response by the police although this may be mitigated to an extent by the fact that the Police Control Room was not informed of Kieran's death until 07.23 hours when they received a telephone call from a staff nurse at NGH. Nevertheless, it was still over an hour after police were notified before a police officer actually arrived at A&E to commence their investigation and it is likely that this delay partly contributed to the events that followed.

5.3.13 Assuming he had finalised his medical responsibilities under the CDRA, it would not be reasonable to expect a Consultant Paediatrician to simply wait around in A&E for over an hour for the arrival of the police, so it is desirable that the police receive notification of a child's death at the earliest opportunity. I am of the view that in clear cases where resuscitation by paramedics is likely to fail or has failed, the EMAS Control Room should alert their counterparts in the relevant police force that a crew has been deployed to a potential SUDC case. I understand this is the usual arrangement in other areas such as West Midlands and South Central so further work should be carried out as to the feasibility of such an arrangement. **RECOMMENDATION 3**

5.3.14 In all cases of SUDC, once the lead investigating police officer has arrived at A&E it is crucial that there is a physical meeting between the *Responsible Paediatrician* and the police officer to ensure direct dialogue and information sharing. *Working Together to*

Safeguard Children (2010, Para 7.79) requires such a meeting and uses the phrase '*When a child dies unexpectedly, a paediatrician (on-call or designated) should initiate an immediate information sharing and planning discussion between the lead agencies (i.e. health, police and local authority children's social care) to decide what should happen next and who will do what*.' It seems then that in the case in question the responsibility for arranging this meeting rested with the *Responsible Paediatrician*, and the local *LSCBN Child Death Review and Response Arrangements,* which the *Responsible Paediatrician* claimed to be aware of, are clear about the purpose of this meeting:

- *At the hospital the Police Investigating Officer and the Responsible Paediatrician will liaise at an early stage to:*

    - *Share all currently available information on the death*
    - *Plan the urgent review of all records held at the hospital*
    - *Agree responsibility for notifying other agencies and professionals of the death and obtaining relevant information from their records*
    - *Plan initial actions to be undertaken jointly by health and police professionals including:*

        a. *Examination of the child's body, obtaining urgent post mortem samples and a skeletal survey*
        b. *Obtaining a full history from the family*
        c. *Formal identification of the child's body*
        d. *Provision of care and support to the family*
        e. *Plan a visit to the home address or other place where the child died*
        f. *Agree arrangements for liaison with the Pathologist*
        g. *Identify and coordinate any other actions required by the agencies own policies and protocols*

5.3.15 It is evident that although there was a meeting (see 5.3.19 below) at 1025am on the ward between the police and the *Responsible Paediatrician*, many of the points required by the CDRA were not covered, and the early part of the inter agency liaison was conducted between the Detective Sergeant and the duty A&E Consultant – in particular the physical examination of Kieran's body when hitherto unseen bruising was discovered. There is no detailed

information as to why the *Responsible Paediatrician* in this case felt he could not return from the ward to A&E but the police record states he '*declined as he was busy with another patient on the ward.*' In a subsequent interview for this serious case review, the *Responsible Paediatrician* claimed that '*he did not recall the* [police officer] *asking him to go back to A&E and examine the child's body*.'

5.3.16 There is clearly an undercurrent within the Police IMR Report that police officers felt the *Responsible Paediatrician* was being intransigent. This is not supported in the analysis within the NGH IMR Report Author and it is not possible to properly reconcile the discrepancy. It is clear however that whatever the reason, the result was a failure to undertake the requirements set out in the LSCBN CDRA. This was not a satisfactory outcome and it is important that NGH ensures a system is in place so that when a SUDC case occurs, the *Responsible Paediatrician* is actually present in A&E to personally lead the multi agency investigation into why the child died. There is a clear need for the *Responsible Paediatrician* to be present in A&E, not least to jointly meet the parents with the police and to jointly examine the child's body with the police. Apart from the fact that the *Responsible Paediatrician* should be eager to receive any relevant police information which may throw light on why the child died, it is not reasonable for the lead police officer to be denied that specialist support and the opportunity for information gathering and sharing.

5.3.17 The key issue at NGH was a failure by the *Responsible Paediatrician* to act in a collaborative and professional manner. The police were evidently trying to engage with the appropriate medical staff in accordance with the multi agency protocol but it is my view that the *Responsible Paediatrician*, whose responsibility it was to co-ordinate and lead this multi agency investigation into how and why Kieran died, failed to do so in a reasonable and helpful way. The *Responsible Paediatrician* informed the NGH IMR author that he was familiar with the LSCBN procedures including the CDRA, and it is noted that in retrospect he agrees that he should have met earlier with the police lead investigator to make 'shared conclusions'.

5.3.18 During the joint physical examination by the A&E Consultant and the Detective Sergeant bruising to Kieran's knees, abdomen, and wrists were noted as well as an injury to the back of his head. The police officer then interviewed the parents as witnesses and they

claimed to be unable to say how the bruising had occurred, stating it was not present the previous day or night.

5.3.19 Having spent two hours in A&E working alongside the A&E Consultant, the police lead investigator decided to then go to the ward to seek out the *Responsible Paediatrician* to try and get a more definitive opinion as to the cause of the injuries. This doctor told the police officer that he felt there were a few concerning bruises but he explained he was not in a position to give an absolute diagnosis. (It should be noted at this point that the next section of this Overview Report will offer a discussion about the training for doctors because it is my view that the failure of the *Responsible Paediatrician* to recognise the serious and extensive bruising on Kieran's body as potentially being caused by child abuse is puzzling and very concerning for the safeguarding of children in the area).

5.3.20 It is the view of the Author of the Health Overview Report that this Paediatrician was erroneously steering police away from the likelihood of non-accidental injury, but nevertheless he did suggest that non-accidental injury remained a possibility. Although this may not have been a firm pointer towards a criminal assault, such an equivocal statement from a doctor is often all that is available in the early stages of any potential assault enquiry, and child abuse is often but one hypothesis within a differential diagnosis.

5.3.21 Because of a perceived hostile climate towards them in recent years, it is well documented (e.g. David, 2005) that many paediatricians are now reluctant to engage in child protection work and are sometimes reluctant to offer a firm diagnosis of child abuse, even when (as in this case) there is cause for concern. Whereas this should not be considered acceptable, the training for police officers should make them aware of this phenomenon and equip them to factor it in to their decision making. Overall, an experienced and well trained police child abuse investigator should have the confidence to seek out whatever facts they can from doctors but ultimately, using investigative skills, their judgement and a healthy scepticism, be able to consider holistically all the relevant factors when deciding whether there is reasonable suspicion that a crime may have been committed.

5.3.22 In this case, it is my view that the following factors which were known to the police at the time, could reasonably have led them

to suspect that Kieran had been the victim of a criminal assault despite the fact that no firm opinion was given by the *Responsible Paediatrician*: (It is also right to point out that had the Paediatrician engaged with the police in a more helpful manner, the following information would also have been shared with him and this may have led to him forming a different opinion).

- An apparently healthy child had died unexpectedly

- No obvious medical signs of natural disease were found (e.g. signs of meningococcal septicaemia)

- The child was immobile yet severe bruises were present the abdomen, knees and wrist, as well as an area of red blood on the back of his head

- The parents had denied to police that the marks had been present when they put the child to bed the previous evening, which seems implausible especially given the fact that the bruising was confirmed by paramedics as being present prior to resuscitation attempts

- The parents had given an inconsistent story to the *Responsible Paediatrician* because when asked about the bruises to abdomen and knees parents they said they were aware of the bruises and had consulted with their GP

- The parents were known to the police, and police records which were available to the lead investigator over the weekend indicated several more recent concerning features such as:

    - Intelligence about drug use within the household,
    - Violent incidents were perpetrated by the father in 2007 and 2009,
    - The mother had been a victim of child sexual abuse,
    - The parents had been on the child protection register

5.3.23 Both the *Responsible Paediatrician* and the Detective Sergeant correctly, and in line with the CDRA protocol, requested that a full

skeletal survey be carried out to assist the diagnosis. The NGH IMR describes how a Consultant Radiologist explained that an X Ray was not possible '*as it was a weekend and the correct level of experienced radiographer was not available, therefore this would need to take place on the Monday following the weekend*.' I believe it is unacceptable that such a basic diagnostic examination could not be done at a large General Hospital at a weekend. Had Kieran been alive, it is clear that an X-Ray might have been a vital component in ensuring the correct medical treatment, but even when a child has died it is important for the reasons outlined in paragraph 5.3.4 above that out of hours radiology services are available. The fact that this diagnostic technique was not available to the lead investigating police officer was undoubtedly a setback in his decision making about whether to commence a homicide investigation.

RECOMMENDATION 2

5.3.24 The ideal person to interpret a baby's X-Rays would be a consultant paediatric radiologist. I would suggest however that even if such a practitioner was not available, an X-Ray should still have been carried out and an initial interpretation made by any duty radiologist or even the *Responsible Paediatrician* who would probably be able to detect major fractures even without specialist radiological training. It is noted that cover at NGH for skeletal X-raying out of hours, will be examined as one of the lessons learnt from this SCR.

5.3.25 The Police IMR Report confirms that on Monday 19th March 2012, '*photographs of the injuries to the deceased were sent to the Forensic Pathologist and Paediatric Pathologist at the Leicester Royal Infirmary in order to seek their opinion. Upon receipt of said images, both parties immediately were of the view this was a case of non-accidental injury*.' The IMR Report goes on to say, *'The significant injuries on the rear of the baby's head were interpreted at NGH as possible lividity but both of the Pathologists discounted this immediately on seeing the photographs'.*

5.3.26 It is not clear when, or by whom, these photographs were taken but in my view they should have been taken shortly after Kieran died by a police photographer *and* sent to the Forensic Pathologist that day. The contract between Northamptonshire Police and the East Midlands Forensic Pathology Unit provides for a 24 hour a day service 365 days a year, and a pathologist should be able to

respond to a request within 2 hours. It is understandable that the full post-mortem examination could not take place until the Monday but had the photographs been emailed to the Forensic Pathologist on the day Kieran died it seems likely that the police would have had the firm medical opinion they were looking for within hours of his death.

5.3.27 The Police IMR Report argues that a *'clearer steer'* from the *Responsible Paediatrician* in interpreting the baby's injuries would have enabled the investigation to have commenced some four days earlier than it did. It is not within the scope of this Review to determine whether the current homicide investigation was detrimentally affected by this delay, but since it is raised as a key issue in the Police IMR Report one assumes that the Police IMR Author feels it did make a difference. If that is the case then undoubtedly a *'clearer steer'* from the *Responsible Paediatrician* would have been helpful to the Police Lead Investigator but in my view even in the absence of such a steer the factors outlined in paragraph 5.3.22 above might be considered sufficient for him to have decided that there was reasonable suspicion a crime had been committed. If an earlier interpretation of the photographs had been requested from the Forensic Pathologist, there would have been an overwhelming suspicion.

5.3.28 Finally, in connection with the theme 'lessons arising from the interface between agencies', there were shortcomings identified by the Health Overview Report in respect of decisions made and actions carried out by the HV service and GP following notification of Kieran's death. On 19th March 2012 Kieran's death activated the child death review process as prescribed in Chapter 7 of *Working Together to Safeguard Children* (2010) but despite the fact that the Child Death Overview Panel meeting was arranged to be held at the GP surgery shortly after Kieran's death, neither the HV mentor, HV student or GP attended the meeting although it would have been expected practice that they attend this meeting.

5.4 Was the required knowledge, skills and experience regarding the identification of and response to child abuse available within agencies? Were there any gaps that may have impacted upon the outcomes for Kieran?

5.4.1 As discussed in 5.2.6 above, a Student Health Visitor (HV) was allocated to Kieran and his family. It is difficult to assess whether a

qualified HV would have managed this case any differently than a student HV although perhaps a student HV might be less well equipped to subtly gather information about the parents by asking gentle but pertinent questions. There is no record within the HV records of advice being shared with Kieran's parents around managing a crying baby, managing behavioural difficulties or any preventative coping strategies.

5.4.2 Having said that, the Student HV identified issues in a systematic way and was detailed in her assessment and followed up her primary visit with an additional visit which was more than expected practice. We now know that Kieran was seriously abused during the time the HV held the case although since it is possible that all the injuries occurred after the last HV contact there is no reason why the Student HV could necessarily have detected child abuse. As described at section 5.2 above however, there was relevant information available but not accessed, which suggested that this might be a risky family, so an examination is required as to whether enough consideration was given when allocating such a family to a student.

5.4.3 The Student HV involved with Kieran's case was a qualified nurse who first registered in 2003. She applied and commenced her HV training in August 2011 and her first week of practice with her HV mentor was in September 2011. The Student HV was undergoing a training course that is both practice based and with theoretical knowledge built around child development including foundation learning, public health issues that affect parenting capacity and the strategies to promote the best health and well being outcomes for children. The Student HV was carrying out independent visits on families from November 2011, two months after starting her training. It is the view of the SCR Panel that going from hospital to the community setting can be very daunting for nurses, but that this Student HV was very capable but let down by supervision.

5.4.4 The decision to allocate her with this case was made by the 'Practice Teacher' or HV mentor, who is qualified to teach students then engage in what is termed 'long arm mentoring'. The decision regarding the Student HV to visit Kieran independently did not appear to have been reached in an informed and professional way. There was no evidence of a formal competency framework of assessment tool

having been used to make this decision by her HV mentor and she had not had any advanced safeguarding training when she was allowed to practice independently. The root of the problem of the flawed decision to allocate a Student HV to this family can be traced back to the general failure by health professionals such as the midwife to access all available information as described in paragraph 5.1.9 above. Had the midwife or HV Mentor accessed the known information about Kieran's parents it should have led to a further and more detailed discussion about their parenting capacity and more detailed consideration about whether a student should have held the case. This may have been exacerbated by the fact that there was no formal documented handover from midwifery to the HV service which is within both the maternity and HV service specification and as such should be expected practice. It should be noted that there was a shortage of Health Visitors at the time of Kieran's birth and the HV Mentor was carrying a caseload of over 700 children as well as supporting the Student HV. This figure is way above a national average of just fewer than 400 cases and is therefore unacceptable, but it goes some way to explain why the supervision sessions were not correctly documented. There is currently a commissioning/provider plan in place to address the shortage in HV's locally and to enact the NHS *National Operating Framework (2012/2013)* within Northamptonshire.

5.4.5 The primary visit of the Health Visiting Service was made on 1st February 2012 when Kieran was 10 days old. In interview with the IMR Report Author, the Student HV stated that she had discussed this family in supervision with her HV Mentor however there was no record of this having taking place. This was a failure in adhering to policy, as NHFT Staff supervision policy states that *"it is the responsibility of the supervisor to keep clear and accurate and up to date records".*

5.4.6 It is my view that the Health Visiting Service did not, in this case, ensure that a practitioner with the required knowledge, skills and experience regarding the identification of and response to child abuse was allocated to Kieran and his family. No blame for this can be attached to the Student Health Visitor concerned and there is no evidence that she missed any signs of abuse or failed to undertake her duties in a professional way. However, in view of the information which was available, she was put in an unenviable position by her

managers, and her supervision may have been less than adequate at least in the sense of recording the supervision sessions.

5.4.7 It is of note that the East Midlands Strategic Health Authority has now published a *Handbook for HV mentors* (2012). This has been developed as 'aide memoire' for mentors to ensure student HV's have the opportunity to meet their learning outcomes. There is a competency framework within the handbook which provides a guide for mentors to enable the student to achieve their proficiencies. In addition, measures have also already been put in place by NHFT Head of Professional Practice Education & Training in liaison with University of Northampton to address identified deficits in respect of safeguarding/child protection training and supervision for HV students in placements.

5.4.8 The Association of Chief Police Officers published national guidelines for the police investigation of SUDC and the revision in force when Kieran died was dated 2011. These guidelines are advisory rather than mandatory but it would be unusual for a UK police force not to adhere to them and the Northamptonshire Police IMR Report makes reference to these guidelines so it is assumed that the Force is aware of them.

5.4.9 In her report, Baroness Kennedy (2004) endorses the ACPO guidelines which suggest that '*the police officer attending a sudden infant death should be a detective of at least inspector rank who has been specially trained for these cases*.' The policy within Northamptonshire Police is to send a Detective Sergeant and Detective Constable to the scene who will notify either the duty Detective Inspector or CPT Detective Inspector by telephone, although it is not a requirement of the policy that the Detective Inspector will 'attend'. In this particular case the police deployed a Detective Sergeant and a Detective Constable from the Child Protection Team, who attended NGH to commence the inter-agency liaison and investigative procedure.

5.4.10 As described in Section 5.3 above, a huge responsibility was placed upon the Detective Sergeant and in my view it would have been desirable, soon after Kieran had been admitted, for a more senior officer to have actually been deployed to the NGH to personally lead the police side of the investigation into his death and conduct

the interaction with the lead paediatrician during the 'Rapid Response' phase.

5.4.11 I believe that it would be wise for Northamptonshire Police to reconsider the force policy about deployment in a SUDC case with a view to ensuring that a Detective Inspector is actually deployed as the hands-on lead investigator in every case as recommended by the ACPO SUDC Guidelines (2011). It is also suggested that a review of training is conducted to ensure that those deployed to lead investigations into SUDC have attended the National Policing Improvement Agency Childhood Death Investigation Course, although it is of note that as a result of this SCR some Detective Sergeants and Detective Inspectors from the Force have now been sent on the training described above. This is a welcome development but it is important that *all* officers who may potentially be deployed to a childhood death as Lead Investigator receive this training as soon as possible.

5.4.12 One of the most striking and puzzling things about this case is that upon receipt of the photographs of Kieran's body both a Paediatric Pathologist and a Forensic Pathologist formed an immediate and unequivocal view that the child had suffered serious child abuse. This is in complete contrast to the position taken by the *Responsible Paediatrician* as relayed to the police after Kieran's admission to NGH where it was suggested that Kieran may be suffering from medical disorders and that child abuse merely 'remained a possibility'. It is noted that whatever the emphasis put on this by the *Responsible Paediatrician* it was consistently made clear that he felt child abuse was one of the possible causes for Kieran's injuries

5.4.13 Hindsight bias is not helpful when analysing practice but asking whether it was *reasonable* for practitioners not to have recognised that which we now know, is a necessary part of SCR analysis. It is now a known fact that Kieran had indeed suffered serious physical injuries, many of which were clearly visible on his body – particularly extensive dark bruising on his abdomen and wrists. When two medical practitioners were able to correctly identify child abuse from a set of photographs, this must legitimately call into question the training of an experienced Consultant Paediatrician who failed to recognise the injuries as child abuse even after examining

the child's body itself. It is important to say that we are not dealing here with some subtle or minor form of child abuse injuries that could reasonably have been missed by most doctors, but rather clear and gross bruising on many areas of the body as well as unhealed 2 – 5 day old rib fractures.

5.4.14 As part of their methodology, the Co-authors of the NGH IMR Report conducted an interview with the Lead Safeguarding Paediatrician for the Trust. During the interview the Lead Safeguarding Paediatrician offered her opinion that the *Responsible Paediatrician* should have been more firm in the potential of NAI, as '*a non-ambulant baby with bruises is rare, and had it been blood cancer there would have been more diffuse bruising*.' The NGH IMR Co-author concluded that perhaps the *Responsible Paediatrician* did not feel he had enough experience to give a definitive diagnosis but offered the view that if that was the case he should have sought a second opinion from someone more experienced.

5.4.15 The Health Overview Report identified that the *Responsible Paediatrician* in this case had received child protection training at Level 3, and also that the CDRA guidelines formed part of that training. This being the case, since we now know that the doctor concerned missed clear child abuse injuries, a review of the actual training given is necessary to establish if it is fit for purpose.

5.4.16 It is not clear from either the NGH IMR Report or the Health Overview Report whether this particular doctor is still performing the role of *Responsible Paediatrician*, or whether he has received further training. Whereas these issues are primarily a matter for the Clinical Director for Paediatrics at NGH, the LSCB should be concerned because had Kieran's parents been the carers for other children, there is every reason to believe such children would have been left at risk for 3 days because of this failure to identify child abuse. **RECOMMENDATION 1**

5.5 With hindsight what, if anything, could have been done differently and what impact, if any, such action may or may not have had on the outcomes for Kieran? Should a referral have been made at any point to Children's Social Care Services?

5.5.1 As expressed earlier in the Report, it is my view and also the collective view of the SCR Panel, that there was no known event or acquisition of a piece of information, which could have reasonably led to any professional being expected to make a safeguarding or child in need referral about Kieran to Children's Social Care.

5.5.2 There were two key points where the actions and the assessments and decisions made by the Midwife or GP may potentially have had a bearing on this case. These were:

1. At the confirmation of the pregnancy
2. At the 6 week check

5.5.3 As described above, during her pregnancy Kelly was not asked the necessary questions regarding domestic abuse although she was asked by the Student HV at the primary birth visit and no concerns were identified. This was a missed opportunity to detect if there was any history of domestic abuse as there are at least three opportunities for this question to be asked during pregnancy. The Health Overview Report highlights how the likelihood of domestic abuse increases during pregnancy and it is for this reason the question should be asked on more than one occasion.

5.5.4 The GP IMR Report comments that formal communication between GPs and Midwives at the very beginning of pregnancy is not a routine aspect of GP care in Northamptonshire. It is further noted in that Report that such transfer of information between organisations is important as the information given to midwives is largely self-declared and may not reflect the historical accumulation of knowledge about a patient. I agree with this position but it was noted in the NGH IMR Report that medical records are not routinely read by community midwives in the antenatal period, *unless there are Safeguarding concerns where risks have been identified*. As Lord Laming (2003), said *'Child Protection cases do not come labelled as such'*, and it should be recognised that in this particular case it was only by

checking the GP Notes, as well as archived hospital notes, that the midwives could have identified any safeguarding concerns.

5.5.5 It is recognised that the high workload of midwives may well prevent routing checking of every mother's medical history, but as described above, this was not a 'run of the mill' family. Kelly was a young, first time mother, in a new and untested relationship with the father about whom little was known. It seems entirely reasonable to suggest that in such a case a more detailed examination of medical notes should be routinely carried out. In Kelly's case, had it been accessed, the accumulation of information as described at paragraph 5.1.6 above should have triggered a CAF which might have led to different lines of enquiry to establish whether Kieran needed extra services from universal providers or even an Initial Assessment by Children's Social Care.

5.5.6 Nine days before Kieran was killed, he was seen by the Student HV for the six week post natal check. His physical wellbeing was recorded as being satisfactory. The following day Kieran and Kelly were both seen by the GP for the medical part of the six week check. There is evidence from the GP records that a thorough physical examination of the baby was undertaken by the GP and there were no concerns noted in respect of any abnormalities with Kieran. The GP systems were followed normally and examinations were carried out in a holistic fashion with a high degree of professionalism and knowledge of the safeguarding requirements that GPs should be performing. Whilst Kieran's parents reported following Kieran's death that abdominal bruising was seen on Kieran's abdomen at the six week check the GP was one hundred percent sure that no bruises were present at that examination.

5.5.7 There is no evidence to support the proposition by Kelly that there were any injuries present on Kieran's body at the time of the 6 week check. The interim report from the Forensic Pathologist revealed that there was *'scarring in the right lung which could be 1 to 3 weeks old, the rib fractures were 2 – 5 days old. and the fatal head injuries 5 hours before death'*. Therefore the only injuries which may potentially have pre-dated the 6 week check were the lung scars which would not have been visible (and even if they had been there are a number of organic causes for this phenomenon), but even these may not have been caused until 2 days after that check. Despite

Kelly's claim, I have no doubt that the bruises on Kieran's abdomen were not present at the time of the 6 week check by the Student HV and GP.

6. Findings from previous SCR's which might assist in the learning

6.0.1 Four previous Serious Case Reviews are believed to be relevant in terms of prior learning.

6.0.2 Recommendations in LSCBN's SCR into Child F and Cumbria LSCB's SCR into Child JM include those in relation to recognising the signs and symptoms of physical abuse and differential diagnosis. The case of Child F had striking similarities in the sense that fairly obvious child abuse bruising was mis-diagnosed by a paediatrician as a rare and obscure condition called Acute Haemorrhagic Oedema in Infancy and other professionals felt unable to challenge this. A recommendation to LSCBN on that occasion included the need to ensure that *'the standards of training agreed by the Board (both single- and multiagency) must immediately reinforce the messages from the Victoria Climbie Inquiry Report about challenging other professionals.'*

6.0.3 Following another previous SCR (Child A) an interagency recommendation was made in relation to teenage pregnancy and support offered to teenage expectant mothers and as a result of this practice changed. However, the interagency provisions for teenage pregnancy have since worsened and it is the opinion of the safeguarding midwife that this now needs to be reviewed and strengthened in Northamptonshire to offer more options to teenage pregnant mothers and this should be inclusive of mothers 19 and under.

6.0.4 Finally, the Northamptonshire SCR known as Child JR revealed that in a different general hospital within the LSCBN area child abuse injuries to a child were not correctly identified. That review also highlighted a concern about the flow of information about the family between different health services, and, as in the current case, relevant information about the parents was held in several different systems - G.P., H.V., Hospitals, Keydoc, NHS Direct, A&E, and Specialist Care - but was not shared or made accessible to the front

line practitioners who may have needed it. Although the recommendations and the action plan from the Child JR review were implemented, the case should be revisited by LSCBN to ensure that in the four years that has elapsed since publication of the Action Plan practice has not reverted to an unacceptable standard.

7. Conclusions and Summary of what has been learnt

7.0.1 There was a considerable body of information in health and education records which indicated that Kieran's parents had both suffered a traumatic childhood. Whether this may have impacted upon their parenting capacity was not considered by those providing a service to Kieran, and it would appear that in any case most of this potentially relevant information remained in archives and was not actually accessed by those working with the family, in particular the midwife at the ante-natal and immediate post birth stage.

7.0.2 The childhood background of the parents, whilst worrying in many respects, was not so remarkable as to be highly indicative of a likelihood that they would inevitably fail to care for Kieran. However, it is reasonable to suggest that had it been accessed the information held in agency files about the parents own troubled background should have triggered a more intensive assessment of their parenting capacity and possibly enquiries under the Common Assessment Framework

7.0.3 The reason for midwives not accessing relevant information about Kieran's parents held by the GP was that without prior safeguarding concerns this would not be routinely done. This is something of a chicken and egg situation because it was only by accessing the GP records that they could have discovered information which may have caused them to conduct further enquiries about Kelly's parenting capacity.

7.0.4 Little was known about Kieran's father and it was revealed during the SCR that paternal medical records are not accessed by community midwives as it is considered that the community midwifes have the professional/client relationship with the expectant mother and the unborn child. It is also perceived to be a breach of the Data Protection Act to access a father's medical records. This latter point is wrong because there is a legitimate interest in a group of health

professionals working with a particular family sharing information to better ensure that the potential vulnerability of a child is properly assessed. In respect of the professional/client relationship, it is also reasonable to expect that each parent with an ongoing primary care-giving responsibility should be considered as a 'client' of the relevant health professionals.

7.0.5 The primary health professional working with the family during Kieran's life was a Student Health Visitor who had been assessed by her HV Mentor as competent to undertake home visits alone. Whilst no evidence was found to suggest that the work carried out by this Student HV was anything other than satisfactory, there were concerns about the process by which she was allocated this family and also a lack of adequate supervision. Had it been accessed, there was sufficient information available to suggest that this was not a suitable family for a Student Health Visitor to have been allocated.

7.0.6 In the hours following Kieran's death a significant breakdown in inter-agency working occurred which might, if not addressed, have a future impact on other vulnerable children with Northamptonshire. The breakdown occurred between the police Lead Investigator and the Responsible Paediatrician and may have been partly caused by the fact that the first police officer did not arrive at A&E until an hour and a half after Kieran had been pronounced dead. This, in turn may have been partly due to a delay in informing the police that Kieran had collapsed at home and died.

7.0.7 The Responsible Paediatrician has specific responsibilities under the LSCBN childhood death protocol (CDRA) which in this case were not entirely fulfilled. In essence, the paediatrician failed to cooperate in a reasonable and professional way with the police and failed to lead a multi agency investigation into how and why Kieran died.

7.0.8 The Review also revealed an apparent failure to identify significant child abuse injuries by the Responsible Paediatrician involved in the case after Kieran had died, and therefore there appears to be a gap in the training of doctors within NGH. In addition, there is a gap in service provision at NGH because it was not possible to carry out a full skeletal X-Ray on Kieran during the weekend he had been admitted to A&E.

7.0.9 The SCR identified concerns relating to the ability of the police Lead Investigator to challenge the diagnosis by the Responsible Paediatrician, and also concerns that despite a considerable body of other evidence, the police felt that only a clear conclusion by the Consultant Paediatrician could give them 'reasonable suspicion' that a crime had been committed. It is evident that Northamptonshire Police does not comply with guidance issued by the Association of Chief Police Officers to the effect that a Detective Inspector should be deployed as the Lead Investigator in cases of unexpected childhood death. Had such an officer been so deployed it is possible that a better evidential assessment would have been made and in particular that a Forensic Pathologist would have been asked to review photographs 3 days before this actually took place.

7.0.10 However, this SCR did not identify serious failures by agencies or professionals which might clearly have had a bearing on the outcome for Kieran, and there is little evidence to suggest that any agency providing Kieran with a service failed to fulfil their responsibilities, statutory or otherwise, to safeguard and promote his welfare.

8 Recommendations for LSCB

These recommendations should be read in conjunction with the Action Plan which provides detail about methods of implementation and timescales.

Recommendation 1

It is recommended that the Chair of LSCBN seeks reassurance from the Clinical Director for Paediatrics at NGH that the safeguarding training for Consultant Paediatricians who are expected to perform the role of Responsible Paediatrician under CDRA protocol has been reviewed in light of this case and is fit for purpose, and that no doctor will be asked to perform that role without such training.

Recommendation 2

It is unacceptable that there is no facility within Northampton to carry out a full skeletal survey on children at weekends. It is

recommended that the LSCB Chair writes to the Director of Nursing for NHS Northamptonshire asking for reassurance that in the LSCB area, radiology, as a diagnostic tool, would be made available for children whenever it was required.

Recommendation 3

The LSCB Chair should ensure that the two constituent agencies, East Midlands Ambulance Service Trust and Northamptonshire Police, report to the LSCB on the feasibility of an arrangement whereby in all cases when an ambulance is despatched to an actual or suspected sudden and unexpected childhood death, immediate communication is instigated between their respective control rooms, thereby reducing the response time for police attendance at A&E.

Recommendation 4

LSCBN should be concerned about a perception by NGH staff that they cannot access relevant notes of the father of a child due to data protection laws. It is recommended that after a review of the legal position is undertaken, the LSCB Chair writes to the Chief Executive of the Trust to seek reassurance that the fathers in potentially vulnerable families will be subject to the same level of enquiry as mothers.

Recommendation 5

The LSCB Chair should write to the Department of Health inviting them to note the perception revealed by this Serious Case Review that information about fathers cannot routinely be accessed or shared between health professionals, and that Midwives only consider the mother of a child to be their 'client'. The Department of Health should be asked to explore whether its own guidance contributes to this perception or does enough to dispel it.

Recommendation 6

The lack of IMR Author capacity available to Northamptonshire PCT was of considerable concern to the SCR Panel. LSCBN must

ensure that all partner agencies, and in particular general practice commissioners, understand all the requirements within the commissioning of IMR's and ensure that authors have capacity for full participation in the review process.

List of References

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Appendix A

Terms of Reference

SERIOUS CASE REVIEW
KIERAN LLOYD – 22.01.12 – 17.03.12

SCOPE &TERMS OF REFERENCE

1. Introduction

1.1. In accordance with the requirements set out in Working Together 2010, the Northamptonshire Local Safeguarding Children Board has decided to conduct a Serious Case Review into the circumstances in which Kieran Lloyd died. Kieran was approximately 2 months when he died. Initial post mortem findings concluded that Kieran had suffered a range of non accidental injuries. Therefore the criteria for a Serious Case Review at 8.9 of Working together 2010 were met in that Kieran died and abuse is suspected to be a factor in his death.

2. Decision to hold SCR

2.1. The case was referred to the Serious Case Review Committee in March 2012 by the Child Death Review Panel. The referral information was that Kieran was found dead at home by his parents. EMAS staff had attended and Kieran was taken to hospital and pronounced dead on arrival. On checking Kieran, doctors reported bruising to the abdomen, wrist and knees. The parents reported that there was abdominal bruising noted at the six week check-up. The bruising found on Kieran following his death was initially thought to be post mortem by the examining Consultant Paediatrician. However, following the Northamptonshire Police enquiry requesting a forensic post mortem examination it was identified that there were several old injuries and healing fractures. The cause of death was therefore recorded as blunt trauma to the head.

2.2. Initial information requests were sent to all agencies and this information was discussed alongside the referral form at the Serious Case Review Committee in April April 2012. The committee also heard information regarding the police investigation into the deaths and that the parents had been arrested. The committee considered the case against the criteria set out in Chapter 8 of

Working Together 2010 and agreed that as Kieran had died and abuse was suspected that it met the following criteria set out in paragraph 8.9:

"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 LSCB should always conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family. These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse. In addition, a SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Young Offender Institution (YOI), a Secure Training Centre (STC) or secure children's home, or where the child was detained under the Mental Health Act 2005."

It was unanimously agreed that a recommendation for a Serious Case Review should be made to the Independent Chair.

2.1. The formal recommendation for Serious Case Review was made to the LSCBN Independent Chair, Ms Janet Galley in April 2012. Her decision to conduct a Serious Case Review was made the following day and was notified to Ofsted and DFE on the same day.

3. Key Issues

3.1 The purpose of the Serious Case Review is as set out at Section 8.6 of Working Together (2010); namely:

a. to establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children

b. to identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result; and

c. improve intra and inter-agency working and better safeguard and promote the welfare of children.

3.2 Paragraph 8.39 of Working Together requires that agencies involved in a Serious Case Review should draw up Individual Management Reviews. These should be based on a comprehensive chronology of involvement by the organisation and/or professional(s) in contact with the children and family over the period of time set out in the review's terms of reference. (This chronology should clearly set out when the children were seen and, where age appropriate, whether the wishes and feelings of individual children were sought). They

should briefly summarise decisions reached, the services offered and/or provided to the children) and family, and other action taken.

3.3 The Individual Management Review should consider the events that occurred, the decisions made, and the actions taken or not taken. Where judgements were made, or actions taken indicate that practice or management could be improved, IMRs should aim to get an understanding not only of what happened but why something did or did not happen. The nature of supervision across agencies should be addressed alongside frontline practice.

3.4 The historical information and the actions or inactions of agencies should be considered alongside the findings, recommendations and actions taken in response to previous Serious Case Reviews conducted by the LSCBN. New recommendations should only be made where there are significant differences in the findings from this review. This should be made clear in the overview report.

3.5 The Serious Case Reviews known to be relevant in terms of prior learning and recommendations are LSCBN's SCR into Child F and Child JR and Cumbria SCB's SCR into Child JM. These recommendations are in relation to recognising the signs and symptoms of physical abuse and differential diagnosis. The relevant recommendations, actions and resulting outcomes are appended as Appendix A.

3.6 The review will consider whether there was information which was known to agencies, or should have been known, that should have identified that Kieran was at risk of serious harm. All agencies should consider the historical information they hold and if there is significant learning from this it should be appropriately referenced and brought into the review.

3.7 Issues which have been identified as requiring particular analysis in respect of the circumstances of this case are:

- What relevant historical information prior to Kieran's birth was known to the agencies about the background and experiences of Kieran's parents? Were there any signs or indicators that Kieran may be at risk and that his parents might not be able to protect him from these risks?
- Were appropriate actions taken by agencies in response to any indicators that Kieran might be at risk of significant harm or vulnerable to becoming a child in need?
- Was the required knowledge, skills and experience regarding the identification of and response to child abuse available within agencies? Were there any gaps that may have impacted upon the outcomes for Kieran?
- Are there particular lessons arising from the interface between agencies? Should a referral have been made at any point to Children's Social Care Services?

- What consideration was given to the level of engagement of both the mother and father when assessing the needs and risk to the children?

- With hindsight what, if anything, could have been done differently and what impact, if any, such action may or may not have had on the outcomes for Kieran?

3.8 Additionally, all IMR authors should also give consideration to issues listed in Working Together "scope and format of IMRs- analysis of involvement" which will also be the subject of consideration by the Overview Author. They are:

- Were practitioners aware of and sensitive to the needs of the children in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about a child's welfare?

- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?

- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?

- Were there any issues, in communication, information sharing or service delivery, between those with responsibilities for work during normal office hours and others providing out of hours services?

- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?

- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?

- Were senior managers or other organisations and professionals involved at points in the case where they should have been?

- Was the work in this case consistent with each organisation's and the LSCB's policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

- Were there organisational difficulties being experienced within or between agencies? Were these due to a lack of capacity in one or more organisations? Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?

- Was there sufficient management accountability for decision making?

3.9 The Individual Management Reviews and Overview Report will be anonymised in relation to this Serious Case Review by authors from the outset as set out in Appendix B.

3.10 Agencies are to consider whether lessons from previous Serious Case Reviews are being effectively learnt and put into action. The commissioning and production of Individual Management Reviews must follow the Working Together guidance at paragraph 8.39 (March 2010) with particular attention being given to SMART recommendations and a comprehensive action plan. The Serious Case Review will identify good practice both in the Individual Management Reviews and in the Overview Report.

4. Time period over which events should be reviewed

4.1 The time period of this Serious Case Review is:

June 2011 to March 2012

4.2 Agencies will need to consider the period from June 2011, when Kieran's mother was believed to be first in contact with services about her pregnancy up to and including March 2012. This time period has been chosen in consideration of the following factors:

ii) The date of Kieran's birth.

ii)The post mortem examination.

4.3 Individual Management Reviews should cover this time period as a minimum. Where there is additional involvement going back beyond these dates (e.g. within the parents' own childhoods) that is relevant to the review, agencies should provide a summary of their previous involvement within the Individual Management Review in the section Background. This should include a summary of early contact with the family relevant to the learning and the approach to multiagency working.

4.4 The SCR will not consider the detail of police investigations initiated as a result of Kieran's death. The Chair of the SCR will liaise as necessary with the police officers conducting that investigation.

5. Involvement of Family Members / Significant Others

5.1. Kevin Harrington, the Independent Chair will write to the parents and other relevant professionals working with them to advise them of the Serious Case Review being commissioned and to request consent for access to their records. The LSCBN Business Manager has been given as their named point of contact. Where there are any issues in accessing adult health records this process will be taken forward by the Designated Nurse as the Health Overview Author.

5.2. Kieran's parents will be given the opportunity to contribute their views directly to the Independent Overview Author by having a meeting if they are agreeable to doing so. As the parents are subject to a police investigation at this time, appropriate advice will be sought by the SCR Panel from professionals involved in this about how any meeting and feedback should be carried out, preserving independence and being sensitive to their needs as grieving parents. Arrangements will be made to offer them feedback at the end of the Serious Case Review process. Consideration will also be given to making contact with any significant other members of the family such as grandparents where appropriate.

5.3. Should there be any indication in the information gathering process that there is information and/or learning to be gained from the involvement or contribution of other family members this will be agreed by the Serious Case Review Panel.

6. Ethnicity religion diversity and equalities / immigration issues

6.1 The members of the family are White British. There are at this stage no reported factors of disability or faith. The Individual Management Reviews and the Overview Report will consider issues of diversity and any relevant aspects of the social and economic environment in which this family lived.

7. Organisations to be involved in this SCR

7.1 The Serious Case Review Panel will comprise of the following members.

- Independent Panel Chair
- Independent Overview Author (in attendance)
- Head of Integrated Safeguarding and Quality Assurance Services
- Designated Nurse for Safeguarding representing Northamptonshire Foundation Health Trust and Northampton General Hospital Trust
- Northamptonshire Police
- NSPCC

7.2 The Panel includes agencies from whom Individual Management Reviews have been commissioned and others who are not directly involved but are able to provide further independent scrutiny from agencies directly involved in the case. The panel will be supported by the LSCBN Business Office team. The Panel will have access to the Designated Doctor who may refer on for any appropriate specialist medical advice needed.

7.3 The following organisations/services in Northamptonshire will be asked to submit Individual Management Reviews or, where indicated, Statements of Information:

- Connexions Northamptonshire (Statement of Information)
- Children's Social Care, Northamptonshire County Council (Statement of Information)
- Education (Statement of Information)
- NHS Northamptonshire (Health Overview Report)
- Northamptonshire Foundation Health Trust (this IMR will combine Community and GP Services)
- Northampton General Hospital Trust
- Northamptonshire Police
- Northamptonshire Probation Service (Statement of Information)
- Housing Services (Statement of Information)
- East Midlands Ambulance Service (Statement of Information)

7.4 At this stage it is not known whether there are any relevant interests outside the main statutory organisations such as voluntary or independent organisations. Where the chronology shows that there is involvement the LSCBN Business Manager will link with them as necessary to secure their involvement.

7.5 Should there be a failure to cooperate with the review this will be addressed by the Independent Chair with the relevant Board member or Chief Officer of the agency.

8. <u>Involvement of organisations in other LSCB areas</u>

8.1 There is no known involvement of organisations in other LSCB areas. Should relevant involvement be identified by the LSCBN Business Manager will take management responsibility for ensuring that the LSCBN negotiates, manages and co-ordinates and other LSCB's involvement in the Serious Case Review process. The LSCBN Serious Case Review Business & Development Coordinator will take operational responsibility on a day-to-day basis being the point of contact between the Independent Chair and Overview Author and Northamptonshire. All contact will be via the LSCBN Business Office address.

8.2 The LSCBN will take the lead in conducting this review and will arrange a briefing for the Individual Management Review authors and will ensure that Commissioners are suitably briefed on the expectations of their authors. In order to complete the review within the mandatory timescales it is essential that timescales are adhered to.

8.3 If any matter relating to cross border working arises during the course of the review and remains unresolved the Independent Chair will seek to resolve the matter with any relevant LSCB. If an issue arises where resolution is not possible by these means the Corporate Director for Adults & Children's will address this with their counterpart.

9. Legal Advice

9.1 There are no issues requiring legal advice at present but the use of legal advice will be kept under constant consideration throughout the process of the Review.

10. Commissioning of an Independent Author & Chair

10.1 An Independent Panel Chair has been appointed who has no previous connection to the LSCBN, SCR Committee or any organisation that potentially should have been involved in the case. Kevin Harrington is an independent person with substantial experience of carrying out and contributing to SCRs. He will ensure that a robust and transparent Review is carried out and that timescales are strictly adhered to via a project management plan. He will also agree a quality assurance process with the Serious Case Review Panel.

10.2 An independent Overview Author has been appointed who has no previous connection to the LSCBN, SCR Committee or any organisation that potentially should have been involved in the case. John Fox is an independent overview author who has considerable experience of working within the safeguarding arena, specifically with LSCBs and conducting Serious Case Reviews. He will draw together all the elements from the Individual Management Reviews, offer engagement with the family members and analyse professional practice into the Overview Report and Recommendations to the LSCBN. He will also provide guidance to the SCR Committee, IMR authors and commissioners on quality assurance of the IMRs.

10.3 The Overview Author should follow the guidance found at paragraph 8.40 of Working Together using the standard LSCBN template. Should the Board regard the report to be of poor quality or fail to ratify the final report there will be an agreed independent mediation process to resolve the issues. This will ensure that the final report meets the standards required by the LSCBN and also addresses the pertinent learning.

11. Expert Opinion

11.1 If the panel consider further specific expertise is identified they will take appropriate action in identifying a suitable expert.

12. Parallel Reviews

12.1 As stated above there is an ongoing Police investigation into the circumstances of Kieran's death. The Police representative on the Serious Case Review Panel will provide updates on progress with the investigation at relevant stages in the process. The Serious Case Review Panel will continually have regard to this and have regular updates to inform the learning within their process. The

Independent Chair of the SCR and LSCBN Business Manager will maintain liaison with the Senior Investigating Officer throughout the Review.

13. Coroner's Inquiries/Criminal Investigations

13.1 The Coroner's Inquest has been opened and adjourned and routes of communication agreed between the LSCBN Business Manager regarding the progress of the Inquest process and Serious Case Review process.

14 Taking into account the relevant learning from research

14.1 Individual Management Review authors will need to review local and national research and learning including the Biennial analysis of Serious Case Reviews.

15. Media coverage/enquiries

15.1 There has been strong media interest in the death of Kieran. This will be kept under review to ensure that any public, family and media interest is appropriately managed before, during and after the review. The Communications & Engagement Committee is aware of the case and will develop a media strategy that reflects the sensitivities of the case.

15.2 The Serious Case Review Panel will consider how Kieran's parents and other relevant family members will be informed of the findings of the Serious Case Review. At the conclusion of the Serious Review the LSCBN will, in line with government guidance, publish the Overview Report and the Executive Summary, unless there are exceptional circumstances which indicate that this would not be appropriate. Publication will be carried out in liaison with the Communications & Engagement Committee who will develop the media strategy as the Serious Case Review progresses.

16. SCR Timescales

11th April 2012 – Decision by Independent Chair

27th April 2012 – Meeting between Independent Panel Chair, Independent Author & Business Office

3rd May 2012 – Serious Case Review Committee

11th May 2012 – IMR Briefing

w/c 14th May 2012 – First version of TOR considered by LSCB Chair

24th May 2012 – IMR Workshop

8th June 2012 – IMR Authors to send first draft of IMRs to Commissioners

9th June 2012 – Commissioners send signed off chronologies to LSCBN

15th June 2012 – Commissioners send signed off IMRs & chronologies to LSCBN

22nd June 2012 – Panel meeting, IMRs presented

29th June 2012 – First draft of GP and NHFT IMR's to LSCBN

20th July 2012 – Second draft of NGH IMR to LSCBN

20th July 2012 – First draft of Health Overview report to Commissioner

27th July 2012 – SCR Panel meeting, GP, NHFT and NGH IMR's to be presented and consider single agency action plans

7th September 2012 – SCR Panel meeting -, second draft of Health Overview Report

22nd October 2012 – SCR Panel meeting to consider second draft of Overview report, Executive summary and multi agency action plans

25th October 2012 – Draft of Overview Report to be sent to LSCBN Chair

13th November 2012 - LSCBN Extra ordinary meeting to receive SCR

30th November 2012 – Submission to DFE

16.1 As above, a timetable has been scheduled according to the timeline attached at Appendix C with dates for the submission of the Individual Management Reviews, Panel meetings, the presentation of the Overview Report to the LSCBN. The submission of papers to DFE was targeted for 31st October 2012. However, this was extended to 31st November 2012 due to the initial post mortem findings being unavailable for consideration within the GP IMR and the Health Overview Report.

17. Liaison with DFE

17.1 Liaison with DFE will by the LSCBN Business Manager who will update the DFE on progress and liaise over requests for extensions.