Northamptonshire Safeguarding Children Board

The Executive Summary

of the

Overview Report

into a

Serious Case Review of the Circumstances Concerning

Child I

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1. Introduction

1.1 What is a Serious Case Review?

1.1.1 A Serious Case Review is held when a child has died, sustained a potentially life threatening injury, or been seriously harmed as a result of being subjected to sexual abuse, and the case gives rise to concern about the way in which local professionals and services worked together to safeguard and promote the welfare of children.

1.1.2 A Serious Case Review examines the ways in which the agencies involved with the family and child worked together and individually to support them. The aim of analysing these cases is to learn how services could be improved in the future to reduce the risk of other children suffering in the same way.

1.1.3 The Government provides advice and guidance on how to conduct a Serious Case Review. These are contained in "*Working Together to Safeguard Children 2010*" which states that:

1.1.4 The purpose of serious case reviews carried out under this guidance is to:

- establish what lessons are to be learnt 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.

1.1.5 Serious case reviews are not inquiries into who is culpable for the harm to a child.

1.2 Summary of Circumstances Leading to the Review

1.2.1 The subject of the Serious Case Review is a child who died at 8 weeks old.

1.2.2 At about 6.25 on the morning of Saturday 17th March 2012, an ambulance was called to the home because the child was reported to have been found cold and unresponsive in a cot by the parents. The paramedics attempted resuscitation and transported the child to the Accident and Emergency Department at Hospital where, despite further attempts at resuscitation, the child was pronounced dead at 7.09am.

1.2.3 It was noted by medical staff that the child had bruising on 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 the child 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 the hospital but he also suggested that a non accidental cause remained a possibility.

1.2.4 Post mortem X Rays and examination of the child 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 the child 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 the child injuries. It soon became apparent that the GP denied ever seeing any bruising on the child or diagnosing abnormal blood vessels.

1.2.6 The parents were later arrested by the police on suspicion of murder. A Serious Case Review is not concerned with establishing culpability but the analysis in the full Overview Report is underpinned by a belief that the child injuries were deliberately inflicted by someone within the household responsible for his care.

1.2.7 The Independent Overview Report Author concludes that no individual or agency had information which could reasonably have led them to predict the events which triggered this review. However, the full Report also describes 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 the child.

1.2.8 The Overview Report also identifies some good practice by agencies and professionals and offers recommendations for action to improve the services offered to children and families.

2. Process of the Review

2.1 Independence

2.1.1 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 a Serious Case Review Panel and the author of the Overview Report must be independent of all of those local agencies that were, or potentially could have been, involved in the case.

2.1.2 To ensure transparency, and to enhance public and family confidence in the process, The Chair of the Northamptonshire Safeguarding Children Board appointed two independent people to lead the Serious Case Review.

Mr Kevin Harrington – Independent SCR Panel Chair

2.1.3 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 project management plan was effective.

Mr John Fox – Independent Overview Report Author

2.1.4 John Fox was responsible for drawing together all elements of the individual agency reviews. He was responsible for analysing the professional practice of professionals and organisations, writing a full Overview Report and making recommendations to the LSCB for further action to better safeguard children.

2.1.5 Neither of these Independent People has had any involvement directly nor indirectly with the child or any members of the family concerned or the services delivered by any of the agencies.

2.2 Individual Management Reviews

2.2.1 The following agencies and organisations contributed to the learning by this Review.

Individual Management Report provided by:
Northampton General Hospital NHS Trust
Northamptonshire Healthcare NHS Foundation Trust - Primary Care GP
Northamptonshire Police
NHS Northamptonshire (Health Overview Report)

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

2.3 SCR Panel

2.3.1 A dedicated Serious Case Review Panel of senior managers from the following agencies was set up to assist with the management of the review and to ensure the maximum amount of learning. Panel membership was as follows:

Kevin Harrington Independent Chair of Serious Case Review Panel
Children's Services Manager, NSPCC
Detective Chief Inspector, Northamptonshire Police
Designated Nurse for Safeguarding Children, NHS Northamptonshire
Head of Integrated Safeguarding and Quality Assurance Services
Standards, Research and Development Manager, LSCBN

3. Conclusions and key lessons learnt from the case

3.0.1 There was a considerable body of information in health and education records which indicated that the child'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 the child, 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.

3.0.2 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 the child. 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

3.0.3 The reason for midwives not accessing relevant information about the child'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 the mother's parenting capacity.

3.0.4 Little was known by professionals about the child'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 only 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.

3.0.5 The primary health professional working directly with the family 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.

3.0.6 In the hours following the child'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 the child had been pronounced dead. This, in turn may have been partly due to a delay in informing the police that the child had collapsed at home and died.

3.0.7 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 the child died.

3.0.8 The Review also revealed an apparent failure to identify significant child abuse injuries by the Responsible Paediatrician involved in the case after the child 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.

3.0.9 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.

3.0.10 However, this SCR did not identify serious failures by agencies or professionals which might clearly have had a bearing on the outcome for the child, and there is little evidence to suggest that any agency providing the child with a service failed to fulfil their

responsibilities, statutory or otherwise, to safeguard and promote the child's welfare.

3.1 What Happens Next?

3.1.1 Recommendations from this Review form the basis of an action plan, which is regularly monitored by the LSCBN Serious Case Review Committee to ensure that the recommendations are completed. In addition to the recommendation contained below, some agencies have drawn up individual recommendations, and each of these each agencies has agreed to implement an action plan to implement the learning in this case.

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 NGHT 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 general lack of engagement in this Review by the Named GP for Child Protection was of considerable concern to the SCR Panel and LSCBN should investigate why this occurred and ensure that any future SCR's are not disadvantaged by such a lack of engagement by a key service provider.