Northamptonshire Safeguarding Children Board

The Executive Summary

of the

Overview Report

into a

Serious Case Review of the Circumstances Concerning

Child J

Independent Author
Dr John Fox **MSc PhD**

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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. At the time this SCR commenced, this guidance was 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 aged 19 months old, but who, at 7 weeks old, suffered a catastrophic attack which ultimately led to the death.

1.2.2 At around 1700 hours on a day in May 2011 the family GP, was called by one of the child's parents who reported that the child was "un-rousable" and "very cold to touch". The advice given was to call 999.

1.2.3 However, 15 minutes later the child was presented at Northampton General Hospital by the parents. On admission the child was found to be unresponsive and in respiratory arrest. The paediatric resuscitation team started work immediately and the child was revived.

1.2.4 Once a full examination had been conducted it was discovered that the child had multiple injuries and the medical opinion was that the cause of the injuries was non-accidental. From the time of the injuries being sustained until the child's death in November 2012, the child remained a very sick child and in particular, suffered from severe brain damage, epilepsy, pain, feeding difficulties, and constipation.

1.2.5 The child's father was later convicted of causing the child's death having pleaded guilty at Crown Court.

1.2.7 The full Overview Report describes what the Serious Case Review revealed about a failure to discover or take into account the troubled background of the father when providing universal services, difficulties in respect of inter-agency communication and information sharing, and in respect of key universal medical services an inability to identify and respond to the significant injuries suffered by the child.

1.2.8 Despite the child being seen by universal primary healthcare professionals shortly before the admission to hospital, and at a time when it is now known the child had significant fractures, nothing was ever discovered by professionals about the maltreatment the child suffered during a short life. As the evidence has been gathered for this review it has revealed that there were opportunities to have done so.

1.2.9 The father was a violent and troubled man and there were many signs that his troubles worsened due to the injuries which he received whilst serving in the army. There were clear indicators, not least some given by the father himself which, had they been properly shared, should have led professionals to be very concerned about the safety of the child. The Independent Overview Report Author concludes that had the information which was known about the father been properly shared amongst the relevant agencies, it might reasonably have led them to predict the events which triggered this review and this should have led agencies to carry out a proper assessment of the child's welfare and safeguarding needs.

1.2.10 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 Kevin 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.

Dr 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)
Armed Forces (compiled by Royal Military Police)
Northamptonshire County Council's Children, Customers and Education Directorate

Factual Report provided by:
East Midlands Ambulance Service
Selly Oak Hospital

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
Chair	LSCBN SCR Committee
Detective Chief Inspector	Police
Associate Director of Nursing	General Hospital
Designated Doctor for Child Protection	NHS
Major	Royal Military Police
Joint Chief Executive	Northampton Women's Aid

3. Conclusions and key lessons learnt from the case

3.0.1 This Serious Case Review concludes that no professional, nor any extended family member, raised any child protection concerns for the child before the admission to hospital in May 2011.

3.0.2 The father caused the death of the child and there is evidence that several months before the child was born, the father had declared to two doctors employed by the Army that he believed he was likely to harm his child if they were left alone together. Neither doctor shared that information with Children's Social Care or the Army Welfare Service and this failure to ultimately share that information with civilian safeguarding agencies was a serious error as it denied those agencies the opportunity to fulfill their responsibilities to safeguard and promote the child's welfare.

3.0.3 Had the information been shared, an initial or core assessment should almost certainly have been triggered and in turn highly relevant further information about the parental backgrounds would have been accessed. Measures may well have then been put in place which could have prevented the child's death.

3.0.4 Despite this failure, there were other opportunities missed to learn more about the father. Family histories and parental backgrounds are crucial to assessments about parenting capacity. A considerable amount of information was stored in Health Service files and databases about the father's troubled early years, some of this information would have been highly relevant to those assessing his parenting ability.

3.0.5 Despite his visible presence during the ante-natal period and at the birth, and despite his obvious physical disabilities, midwifery staff failed to take active steps to ascertain the identity of the father or to offer him support. Midwifery staff did not sufficiently 'Think Family' when they were providing a service to the child and her mother, and this was contrary to the national guidance provided by the Nursing and Midwifery Council.

3.0.6 The child had been seriously injured by the time of a routine 6 weekly checkup which was carried out by universal primary healthcare staff and a non routine visit to the GP the following day. When the checks were conducted it is now known that the child had several recent fractures to ribs, arm, spine and leg, yet nothing untoward was noticed. The check was carried out in accordance with current service provision guidelines which may indicate that the current standard practice for conducting such checks is in need of review.

3.0.7 A number of vulnerability factors were identified at the 6 week check, such as the mother feeling low and the father having serious injuries, and it was noted that the child's weight had dropped from the 25th centile to the 9th centile. No steps were taken by the universal primary healthcare team to meet with the father and no concerns were raised in connection with the vulnerability factors. A plan was made to monitor the child's weight over a 4 week period but this was pre-empted by the catastrophic assault which led to her admission a few days later.

3.0.8 The care provided by medical staff to the child, from the time of admission to A&E in May 2011 until the death 17 months later, was first class. The police criminal investigation was conducted in a highly professional manner and the Senior Investigating Officer provided a great deal of help to this SCR.

3.0.9 This Serious Case Review was not commenced until the child died, many months after receiving the injuries. A key element of such a review is to establish from professionals working with the family why things happened in the way they did. Due to the length of time that elapsed from their dealing with the family to them being asked to recall events, memories have faded and as a consequence the learning from this review is sub-optimal. To have achieved the best outcome in terms of learning lessons, this Serious Case Review should have been commissioned shortly after May 2011.

4. What Happens Next?

4.1 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.

5. Recommendations for LSCBN

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

RECOMMENDATION 1

When children are presented to hospital with suspected non accidental injuries, the hospital staff should make simultaneous referrals to both social care and the police, and that LSCBN Child Protection Procedures should be amended to reflect this.

RECOMMENDATION 2

The LSCB should request that NGH and NHFT review their midwifery processes to ensure they explicitly contain an expectation that throughout the pregnancy and post natal period midwives and health visitors routinely continue to make active enquiries about the identity of the father of the unborn child, the parental relationships and parental figures. The LSCB Chair should write to the Nursing and Midwifery Council to make them aware of the key issues relevant to them arising from this Serious Case Review.

RECOMMENDATION 3

The LSCB should convene a working party to explore the barriers to midwives and health visitors gathering information about fathers within families and supporting them. Through imaginative and mature multi agency discussion, the working party should actively look at ways in which any culture not to engage with fathers can be challenged.

RECOMMENDATION 4

A formal written handover between midwives and health visitors is essential to safeguard children. The LSCB should ensure the process for doing this is implemented and working seamlessly.

RECOMMENDATION 5

To ensure adequate safeguarding of children within military families there is a need to examine, and if necessary improve, training for military doctors and the information sharing arrangements between military medical and social work teams and their civilian counterparts. The LSCB Chair should write to the Ministry of Defence indicating that this Overview Report has significant lessons for the Armed Forces and that they should

consider working with the material from the Armed Forces IMR to draw up a document outlining how the military should work in terms of safeguarding, safeguarding training specific to military medical personnel, and information sharing.

RECOMMENDATION 6

The LSCB Chair should write to the Department of Health and suggest they invite the relevant professional bodies, such as the Royal College of General Practitioners, to examine the case which triggered this serious case review and consider whether there are further reasonable tests or steps which could be could be taken at the 6 week stage to determine whether a baby has suffered from gross injuries of the nature described in this report.

RECOMMENDATION 7

The LSCB should use the learning from this case to remind all agencies of the requirement that they should refer a case to LSCB if it meets the criteria for consideration of a Serious Case Review or other case learning.

RECOMMENDATION 8

LSCBN Child Protection Procedures should be amended slightly to include a specific responsibility on the LSCB agency delegates themselves to support any member of staff from their agency who feels a case may meet the SCR threshold. It should be the case that it is the responsibility of the LSCB delegate from any of the LSCB partner agencies to trigger consideration of a Serious Case Review if they feel the criteria are made out. The LSCBN Procedures should be amended to make this clear.

RECOMMENDATION 9

The LSCBN should refer the serious case review to the Adult Safeguarding Board so that they can consider whether there are any issues regarding the support for the adults involved in this SCR.