Executive Summary

SERIOUS CASE REVIEW
IN RESPECT OF A CHILD
V

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INTRODUCTION

The Local Safeguarding Children Board Regulations, 2006, require Local Safeguarding Children Boards to undertake reviews of serious cases. In August 2009, when this Serious Case Review commenced, the applicable guidance on conducting such reviews was at Chapter 8 of Working Together to Safeguard Children 2006. This has subsequently been revised by Working Together to Safeguard Children 2010. The provisions of the more recent guidance are not however retrospective and this Review has been completed in accordance with the 2006 document.

A Local Safeguarding Children Board should always undertake a Serious Case Review when a child dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death. This is irrespective of whether Local Authority children's social care is, or has been, involved with the child or family.

The purpose of a Serious Case Review is to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- Identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children.

Serious Case Reviews are not inquiries into how a child died or who is culpable. That is a matter for the Coroners and criminal courts, respectively, to determine as appropriate.

Summary of Circumstances Leading to the Review

V was an only child and in June 2009, when 4 months old, was taken to the family GP in a collapsed state. The child was initially taken to the local hospital Emergency Department where a severe brain injury was diagnosed, then transferred to the paediatric intensive care unit in Oxford. It was identified that V's brain injury was irreversible and that further medical intervention would be of no benefit. Treatment was withdrawn in consultation with V's family and the child died shortly after.

A criminal investigation in relation to the death of V has been conducted by Thames Valley Police. The partner of V's maternal aunt was found guilty on 20 July 2011 of Manslaughter and was sentenced to 6 years imprisonment.

The Serious Case Review sub-group of Oxfordshire Safeguarding Children Board (OSCB) considered the circumstances of V's death and recommended that a Serious Case Review be conducted. That recommendation was endorsed by the Independent Chair of the Board on 3 August 2009.

Terms of Reference

Draft Terms of Reference were agreed by the Oxfordshire Safeguarding Children Board Serious Case Review sub-group.

The final Terms of Reference identified that the Review, whilst commissioned by the Oxfordshire Safeguarding Children Board, would be reported not only to that Board but also the Reading Safeguarding Board because the original Hospital where V was treated was in the Reading area although the matter was at all times an Oxfordshire case.

Key features in the case, for consideration in the Review, were:

- Agencies should consider whether relevant information about any of the adults was known by agencies during the ante-natal period and whether it was considered adequately and whether appropriate action was taken and if not why not
- Were there any previous incidents which raised child protection concerns about V's care and were they responded to appropriately by agencies, specifically an earlier incident which necessitated attendance at the local Emergency Department
- Agencies should review records relating to the parents of V's cousin, which is relevant to subsequent decision making in the care of the child and identify any risk factors known relating to that child and if so, was the information appropriately shared
- Whether race, religion, language and cultural needs were met during intervention with the family by all agencies to include learning disabilities and or any mental health issues
- Police and Children's Social Care to review their initial response during the first 48 hours post incident. To analyse any actions in relation to how agencies worked together to safeguard V and cousin during this time.

Serious Case Review Panel

The Serious Case Review Panel was chaired by Andrea Hickman, Independent Chair of the Oxfordshire Safeguarding Children Board.

Chris Few, an independent consultant, was appointed to write the Overview Report at the outset of the Serious Case Review. He had conducted an agency management review for Education Services as part of a previous Serious Case Review in Oxfordshire but otherwise has no personal or professional connection with any agency in the county.

Other members of the Serious Case Review Panel were:

- Lead Solicitor
  Oxfordshire County Council
- Superintendent
  Thames Valley Police
- Designated Nurse
  Oxfordshire Primary Care Trust
- Deputy Director Corporate Affairs
  Royal Berkshire NHS Foundation Trust
- Designated Doctor
  Oxfordshire Primary Care Trust
- Lead Officer Safeguarding
  Oxfordshire County Council
- Business Manager
  Oxfordshire Safeguarding Children Board

Review Process

It was recognised at the first panel meeting that the Serious Case Review would not be able to be completed until after the conclusion of the Police investigation. All extensions to the timescale for the Review were agreed by the Panel, in consultation with the Government Office South East (GOSE).

The Serious Case Review Overview Report was presented to, and accepted by, the Oxfordshire Safeguarding Children Board on 13 October 2011.

The Overview Report and this Executive Summary have been copied to the Chair of the Reading Safeguarding Children Board with an offer to formally present it at a meeting of that Board.

Action was taken during the Serious Case Review process to ensure that identified learning was implemented at the earliest opportunity.

Contributions to the Review

Individual Management Reviews (IMRs) were received from:

- Thames Valley Police
- Oxford Radcliffe Hospitals NHS Trust
- Community Health Oxfordshire
- Royal Berkshire NHS Foundation Trust
- Oxfordshire County Council – Children's Social Care.

These were supplemented by:

- consulting relevant research reports
- access to policy and guidance documents
- copies of documents and records from meetings and communications
- correspondence with individuals and agencies to confirm and clarify information.

Family Engagement

Family members were informed that this Serious Case Review was taking place. Following the conclusion of the criminal investigation they were invited to contribute to Serious Case Review but did not do so. It is intended that the findings of the Review will be shared with family members prior to publication of the Executive Summary.

SUMMARY OF EVENTS SURROUNDING THE DEATH OF V

- The child's mother brought V to the family GP surgery in a collapsed state. V had suffered a head injury, was critically ill and in respiratory arrest. V was transferred to a local Emergency Department.
- Owing to the seriousness of V's condition, the child was transferred to the Paediatric Intensive Care Unit (PICU) at Oxford.
- At the PICU it was identified that V's injuries had resulted in irreversible brain damage. This was discussed by medical staff with family members and it was agreed to withdraw further treatment.
- V was christened and died shortly afterwards in mother's arms.
- From the outset it was suspected that the injuries sustained by V were not accidental. It was reported that V had been in the care of one or more adults within the family during the hours preceding admission to hospital.
- Referrals were made to Oxfordshire Children's Social Care in relation to both V and to V's cousin (the child of V's maternal aunt and her partner). These were reported to the Police.
- As a result of these referrals a criminal investigation in respect of the injuries to V and a child protection investigation in respect of V's cousin were instigated.

Cultural and diversity issues

The children and adults in this Serious Case Review are all white British and from English speaking families.

The family of V were identified as being members of the Church of England by both hospitals involved and account taken of their faith in arranging for V to be christened before he died. No other diversity issues were identified during agencies' contact with the family.

LEARNING FROM THE REVIEW

This Review is perhaps unusual in that the greatest learning relates to events *after* the incident that led to it being commissioned. This learning is no less important for that.

Lessons learned from practice prior to V's death

- Prior to the incident, professional involvement with V and family was mainly in relation to universal health service provision.

  In April 2009 V sustained a minor head injury whilst in the care of mother. As the fatal injuries to V were inflicted by the partner of V's maternal aunt, it is highly unlikely that any response to V's injury in April 2009 could have led to his death being either predicted or prevented. This judgement is however made with the benefit of hindsight and there should have been more of an investigation into the circumstances of how the injuries occurred in a non-mobile child.

  Therefore, all injuries to non-mobile infants should be regarded as highly suggestive of non accidental injury unless there is an adequate explanation. The plausibility and consistency of any explanation with an injury needs to be carefully considered.

- The partner of V's maternal aunt (convicted of causing V's death) was misusing steroids and had previously sought medical attention for injuries that suggested aggressive behaviour. This was known to his GP and hospital staff. . However no professional could reasonably be expected to have identified that this might pose a risk to V.

  Awareness of parental misuse of steroids as a potential risk factor for children should be improved.

Lessons learned from practice after V's death

- There were deficits in the processes by which the injuries to V were referred to Children's Social Care and then to the Police. The principle Police focus was in relation to the criminal investigation to the detriment of clearly establishing V's cousins whereabouts and safety. Action taken to safeguard this child did not happen until over 24 hours after V's admission to hospital and in one instance, potentially placed the child at risk. Fortunately V's cousin was not harmed during this period.

  When abuse or neglect is suspected, the referral of this to Children's Social Care and the Police should include details of any other children who are in contact with a suspected perpetrator and this must result in action to assess and respond to the safeguarding needs of those children.

- The Police did not respond to persistent requests for information as to the whereabouts of Vs cousin from Children's Social Care. This should have been escalated more robustly by Social Care. As a consequence there was a lack of joint working on this issue.in first two days after the injury to V were characterised by poor communication; a lack of joint working; a focus by the Police as an organisation and by individual staff members on the criminal

investigation to the detriment of their safeguarding responsibilities; and a failure within Children's Social Care to fully adhere to, and ensure compliance by other agencies with, child protection procedures. Escalation procedures were engaged by Children's Social Care but should have been pursued more robustly.

All Police staff should understand that they have a responsibility for safeguarding children, which is as important as their responsibility to detect crime. They should know about, and comply with, the national and local policies, procedures and guidance on how they should exercise that responsibility.

Children's Social Care must insist on compliance with, national and local policies, procedures and statutory guidance on safeguarding children; persistently using established escalation procedures to secure this compliance where necessary.

Areas of Good Practice

- Following the injury in June 2009 the response of health agencies to the medical needs of V was appropriate and gave V an optimum chance of surviving the injuries. Sadly they were too severe for these efforts to be successful.
- The health service response to the emotional and spiritual needs of V's family was also appropriate and effective.
- The initial referral by the Emergency Duty Team Co-Ordinator to the Police Enquiry Centre was of a high standard, both in terms of an accurate summary of events and clarity of the issues.

CONCLUSION

It is the conclusion of this Serious Case Review that the death of V could not reasonably have been either predicted or prevented by any professional.

The contributing Individual Management Reviews also identified specific areas in which organisational and individual practice could have better contributed to safeguarding children and made recommendations to have these addressed. These are outlined at Appendix A.

RECOMMENDATIONS

The implementation of recommendations from both the Individual Management Reports and the Serious Case Review are the subject of current action plans developed by the Oxfordshire Safeguarding Children Board. All agencies have internal systems for monitoring implementation of the actions, progress is also reported to that Board via the Quality Assurance and Audit subgroup.

1. That the Oxfordshire Safeguarding Children Board and Reading Safeguarding Children Board ensure that their procedures in relation to the recognition of physical abuse are sufficient to ensure that that any traumatic injury to a child who is not independently mobile is considered as highly suggestive of non accidental injury unless there is an adequate explanation, the plausibility and consistency with the injury of which has been confirmed by experienced medical opinion.

2. That the Oxfordshire Safeguarding Children Board and Reading Safeguarding Children Board ensure that the significance of injuries to children who are not

independently mobile is highlighted in their multi-agency training provision and the training provided by their partner agencies.

3. That the Oxfordshire Safeguarding Children Board ensures that reference to non-prescription steroid use is included in its multi-agency training provision and the training provided by its partner agencies in relation to parental substance misuse.

4. That the Oxfordshire Safeguarding Children Board and Reading Safeguarding Children Board ensure that their child protection procedures and all referral documentation used by their partner agencies require and prompt the inclusion of details regarding other children within the household or in contact with the alleged perpetrator of child abuse.

5. That Thames Valley Police ensure that all of its staff understand and accept their responsibility for safeguarding children and are aware of the procedures and guidance within which they should exercise that responsibility.

6. That the Oxfordshire Safeguarding Children Board require Oxfordshire County Council Children's Social Care and Thames Valley Police to provide reports on how they will ensure compliance by their organisation and staff members with national policies, statutory guidance and local procedures in relation to joint working and information sharing to protect children.

Reading LSCB have indicated that they accept all recommendations and have implemented all required actions.

In addition to the recommended action, the Overview Report Author brought recognition of parental steroid use as a concern for children to the attention of the National Safeguarding Delivery Unit for consideration of including it in the revised version of Working Together to Safeguard Children, (2010).

This Review has been submitted to Ofsted and evaluated by them as Good.

Appendix A

Agency Management Report Recommendations

Community Health Oxfordshire & Oxfordshire Primary Care Trust

1. Guidance for follow up of A&E attendances to be developed for Universal Children's Services including the recommendation that a contact should be made to discuss safety issues with parents/carers when a child presents with an accidental injury under the age of one year old.

2. The significance of A&E attendances as a possible risk factor for children and young people to be captured in Community Health Oxfordshire's safeguarding children and young people training and group supervision sessions.

3. Content and style training to be included in future documentation training. Review of Health Visitor documentation in the GP electronic records to be included in the safeguarding reviews undertaken by the Safeguarding Team.

4. The induction process for skill mix staff to formally include the use of the Staff Nurse Handbook and the process to be audited across Universal Children's Services to ensure consistency across teams. This should include ensuring protected time is in place for supervision of community staff nurses and nursery nurses.

5. Routine enquiries to be asked of mothers regarding domestic abuse to be included in the Healthy Child Program for implementation across Universal Children's Services. Community Health Oxfordshire's domestic abused strategy and guidelines to be adopted across Universal Children's Services once ratified by Clinical Standards.

6. Information regarding reducing the risk of "Shaken baby" and the vulnerabilities of babies to be given by universal children's staff to all families as part of the primary birth contact.

Royal Berkshire NHS Foundation Trust

1. Include consideration of the developmental stage of babies and children in child protection training for A&E and paediatric staff concerning indicators of physical abuse.

2. Review the system used to inform Health Visitors about the attendance of children at the A&E department, particularly infants under 1 year of age.

3. Consider the inclusion of the use of non-prescription steroids in child protection training concerning the impact on the care of children when parents/carers misuse substances.

4. Ensure that all staff working with adults are aware of the high risk factors that are associated with significant risk to children particularly substance abuse, domestic violence and mental illness.

5. Review and modify the RBNHSFT child protection referral form to prompt consideration of all children who may be at risk not only those in the immediate household.

Oxford Radcliffe Hospitals NHS Trust

1. Staff should explicitly identify who is present and who they communicate with, using names not just family role. Explicit documentation of family members and their behaviours assists in developing a more comprehensive and holistic record enhancing individualised care and provides greater understanding of the social situation.

2. Documentation in cases of probable non-accidental injury should also include a comprehensive record of all actions being taken to assess and safeguard all members of the extended family who may be considered at risk.

Oxfordshire County Council Children's Social Care

1. Children's Social Care and Police should be required by the Safeguarding Board to affirm that they will in future adhere to and comply with national standards for responding to child welfare concerns and OSCB procedures and will swiftly escalate any incident of non-compliance by another agency.

2. A written out of hours agreement or protocol should be drawn up between Police, Social Care and Health which creates a clear expectation that feedback on agreed actions will take place and is specific about how, when; and by and with whom.

3. SCB should make a formal request to Children's Social Care to ensure that recording includes (a) the identities of staff undertaking all actions; and (b) decisions with reasons.

Thames Valley Police

1. Named officers within this review should be advised where their actions were viewed to fall short of what was expected and training provided to address this if required.

2. Control Room procedure should be reviewed to ensure that when a single report is received detailing two separate serious incidents that both are dealt with expeditiously and appropriately. It will also enable clearer lines of communication with partner agencies.

3. Force Senior Detectives should be reminded of the need for the on call Detective Inspector to attend and take initial charge of the investigation unless there is a good reason for non attendance. They should be sure that all officers involved, including the CAIU DC, understand what their role is and what their objectives are in that role.

4. Officers involved in this case to be advised that CEDAR entries should be created in a timely manner, accurately kept and detailed to show actions taken until Major Crime have taken ownership of the case.

5. Where there are concerns about the welfare of a child, Social Care should be requested to attend addresses with police unless a risk assessment indicates this would not be safe. This would assist officers in establishing the suitability of carers for a child.

6. Training for the CID officers involved on the importance and procedure of safeguarding children.

7. Senior detectives involved to review guidance to ensure they are clear when there is a requirement to attend and the roles of specialist staff being deployed.

8. When there is a serious incident involving a child/ children, where the Major Crime Unit are involved it is essential that there is a named Single Point of Contact within the Police and Social Care in order that communication is maintained. This link is vital to prevent a breakdown in information sharing at a critical stage.