OXFORD SAFEGUARDING CHILDREN BOARD

Serious Case review

Executive Summary of Overview Report

Concerning the death of

Child Y

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Nov 2013

Introduction

This Serious Case Review was initiated following the death of a 22 month-old boy on in November 2010. He was admitted to hospital in November 2010 with serious head injuries and died a week later. The father has since been charged with, and pleaded guilty to child neglect. The child's older half-sister (same mother, different father) is placed with her father. The child's full sister (same mother and father) is placed in the care of foster parents.

Legislation and statutory guidance require Local Safeguarding Children Boards to carry out a Serious Case Review in circumstances in which it appears that a child has died and abuse or neglect is known or suspected to be a factor in the death.

After consultation with Ofsted, the Chair of Oxfordshire Safeguarding Children Board (OSCB) decided that a Serious Case Review should be carried out in accordance with statutory guidance and protocols adopted by the Board.

A Serious Case Review's aim is to examine the circumstances of the events leading to a child's injury or death, and to ascertain whether lessons can be learnt by agencies to make less likely their reoccurrence in other children's cases.

Independent Overview Report

The Overview report brings together and analyses the findings of the various reports from agencies and others, and makes recommendations for future action.The Overview report has been written by Independent Author Malcolm Ross. The role of Independent Panel Chair was then taken by Andrea Hickman, who is Independent Chair of the Oxfordshire Safeguarding Children Board.

This is an executive summary of the Overview report, which has been compiled by Malcolm Ross in conjunction with the Serious Case Review Panel. It makes three recommendations along with one reminder of practice; these are listed at the end of this summary.

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The Individual Management Review Reports

The following agencies had involvement with Child Y and his family, and carried out Individual Management Reviews and produced reports of their involvement with the family:

- Oxfordshire County Council – Children, Education and Families Directorate (previously Children, Young People and Families)
- Cherwell District Council
- Connection Floating Support
- Thames Valley Police
- South Central Ambulance Service
- Oxford University Hospitals NHS Trust (previously Oxford Radcliffe NHS Trust)
- Oxford Health NHS Foundation Trust (previously Community Health Oxfordshire NHS Trust and Oxfordshire and Buckinghamshire Mental Health NHS Foundation Trust)
- Oxfordshire Clinical Commissioning Group (previously Oxfordshire PCT)

The recommendations in the Individual Management Review reports were accepted and adopted by the agencies that commissioned the reports and supported by the Overview report.

Serious Case Review Panel

Agencies nominated a Serious Case Review Panel of professionals to carry out the Serious Case Review, discuss the reports and consider the issues that arose. They were;

- Mr Malcolm Ross, Independent Consultant
- Mrs Andrea Hickman, Independent Chair of the Panel

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In addition, the other professional members of the Panel were:

- Deputy Director, Children's Social Care, Oxfordshire County Council
- Designated Nurse, NHS Oxfordshire
- Designated Doctor, NHS Oxfordshire
- Detective Chief Inspector, Thames Valley Police
- Head of Legal and Governor Services, Oxfordshire County Council
- Safeguarding Manager, Oxfordshire County Council
- Business Manager, Oxfordshire Safeguarding Children Board

All meetings of the Panel were conducted in an open, honest and thorough manner; the Review was carried out in accordance with statutory guidance.

Purpose, Scope and Terms of Reference

The purpose of the Serious Case Review was to identify steps that might be taken to prevent a similar death and in so doing to

(a) Establish what lessons should be learned
(b) Establish how lessons should be acted upon, and what should change
(c) Improve inter agency working to better safeguard children
(d) Identify examples of good practice.

All agencies carried out Individual Management Reviews and produced reports of their involvement with the family. They each completed a chronology of involvement from February 2005 (first pregnancy of mother) to November 2010. The chronologies outlined when Child Y, the older sibling or the parents had been seen, or when there had been communication relating to each child. The chronologies contained a summary of any observations, actions taken or services offered.

Independence

The government guidance requires that those conducting agency reviews of services should not have been directly concerned with the child or family, given professional advice on the case, or be the immediate line manager of any practitioners involved. The Overview report author confirms that this requirement was met.

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Family Involvement

Government guidance requires that consideration be given to how members of Child Y's family might be involved in the Review. Both mother and father were arrested by the police shortly after Child Y died and were subject to police bail for a considerable period of time. The father was charged with the offence of neglecting Child Y and received a custodial sentence. The mother has since moved to the Republic of Ireland. They have not been seen by the author or chair of this review - this was a decision made by the Panel based on the family circumstances.

Summary of Information

The Review considered a summary of background information as set out in the scoping and term of reference:

Child Y's older sibling was born in early 2006. Child Y was born in early 2009 and died in November 2010, aged 22 months.

Mother of Child Y had a troubled upbringing. She had behavioural issues at school that led to suspension, and became involved with alcohol and drugs. She became pregnant at the age of 18 and was living with her partner, Father 1, who was aged 21. Child Y's elder sibling (Child X) was born in early 2006 and the family were seen routinely by the health visitor following the birth. In October 2006 the family moved to another part of the England where the father's family resided. Health records were requested from this area as part of the SCR process and since none were found it is likely transfer of records did not take place. The 8 month development check and the Edinburgh Post Natal Depression assessment, due at this time, could not be evidenced as having taken place.

By February 2007 mother and father had separated and mother returned to Oxfordshire with Child X to the maternal grandmother's house, which proved to be wholly unsuitable. Later that month, mother reported to her GP that she was having difficulty coping with her work and housing problems. The GP recommended the assistance of a health visitor.

The Local Housing Officer attempted to assist Mother with alternative accommodation and provided a two-bedroomed tenancy. However she immediately hit financial problems. She reported that she was feeling depressed. At this time mother was 20 years of age and Child X was 15 months old.

In September 2007 mother reported that her house had been broken into and property stolen. She blamed her former partner for this, who was arrested and interviewed but no further action was taken due to inconclusive evidence. Mother was in a relationship with a man who was to later become Child Y's father.

During the early hours of New Year's Day 2008 Police were called to mother's house as she had taken an overdose and had cut her wrists. She was taken by ambulance to hospital and was seen in the accident and emergency department and referred to the liaison mental health nurse. This practitioner contacted the GP to say that mother had been encouraged to self-refer to the Complex Needs service (within adult mental health) and contact the Citizen's Advice Bureau regarding her debts. There followed several visits to her GP. Although mother did discuss personal problems with her GP she reported that she was coping well with her child.

Problems for mother continued with rent arrears and debt. The new partner (referred to now as father 2) also had debt problems. This was followed by a short period of depression for mother and she received medication from her GP. By May 2008 mother was pregnant by father 2. This put extra strain on the housing situation.

In October 2008 mother reported that she was having problems with her ex-partner pestering and harassing her. She contacted the police who looked into the matter and issued her ex-partner with a Harassment Warning Notice preventing him from continuing to approach her. This resulted in no further harassment.

In early 2009, Child Y was born. At the Primary birth visit by the health visitor mother reported to feeling well but was concerned about the poor quality of her flat and the possibility of eviction.

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In September 2009 Child Y was taken for a routine vaccination at the GP's, when a nurse practitioner noticed that he had bruising to his cheek and forehead and a graze on his nose. This was appropriately referred to social care by the practice nurse. Later the same day police and social care visited the family home and persuaded mother and father 2 that Child Y required examination at hospital. Mother and father 2 said that Child Y had fallen asleep with his head against cot bars and he had also been on the floor and banged his head on a metal dividing strip between rooms, causing the facial injuries. The paediatrician who examined the child found their explanation credible and accepted it. The judgement of the paediatrician was not challenged and his decision was made with only an explanation from the parents and without due consideration of all of the facts known to the police, the nurse practitioner and social care.

There is no record of a review strategy meeting where all of the facts could have been shared and an informed assessment made about the injuries and the likelihood of abuse or neglect. There was a two month delay before the paediatrician's report was completed and shared with social care.

In June 2010 social care received an anonymous referral reporting that Child Y had developmental delay and possible bruising from falling over. This incident was not recorded properly or investigated fully by social care and only came to light during the period after Child Y's death. Appropriate disciplinary action has been taken by social care.

In November 2010, mother and father 2 took Child Y to the A&E of the local hospital. He was found to have extensive serious injuries to his head which included a fractured skull. He had bruising to his abdomen and his skull which doctors suggested were quite fresh. He was transferred to another hospital where his condition remained critical until he passed away a week later.

Explanations given to the doctors and the police from the parents were inconsistent with the injuries caused. Both parents were on police bail for many months while forensic tests were completed on Child Y. Eventually father 2 was charged with the offence of neglect.

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Commentary

Each agency submitted a report of their involvement with the child and family, and from those reports the Independent Author identified these areas which necessitate comment:

Assessment of mother during the ante-natal period – Child Y's older sibling

Communication between the health visitor and midwife was not evidenced in the review. The health overview report highlights the missed opportunity to complete an ante-natal assessment, but it also reports that current practice is that a formal ante-natal pathway is in place. Had this been in place at the time, additional vulnerability factors for mother, such as periods of abuse from an ex-boyfriend may have been identified.

Assessment of emotional and mental health and impact on parenting

There is no record of documentation of the Edinburgh Post Natal Score (EPNS) being conducted after the birth of sibling in 2006, either in the new area when mother moved out of Oxfordshire, or on her return to Oxfordshire.

There is guidance in place regarding the completion of a depression assessment following birth, and the Community Health Oxford Individual Management report reminds professionals that, 'When a family moves to another area all practitioners in Community Health should ensure that professionals in the new area are contacted and all outstanding medical issues are pursued in that new area.'

When mother took an overdose and cut her wrists in early 2008 she was taken by ambulance and was treated at the A&E of the local hospital. The significance of this episode in terms of mother's emotional/ mental health and of the older sibling's welfare was not fully considered by all agencies and there was no effective information sharing.

There was no direct referral from the liaison mental health nurse or the hospital to the health visitor. The health visitor remained unaware of the full information in the

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mental health assessment carried out by the liaison mental health nurse, including a previous abusive relationship mother had suffered from between the ages of 14 and 17 years, her low self-esteem, work problems, and a recent burglary she had been a victim of.

Recommendation (1)

All agencies to be reminded that when dealing with adults who have identified mental health needs, consideration must be given to the wellbeing and safety of any children and to the potential impact on parenting capacity of the parent/carer, and information is to be shared to prevent a child being at risk of significant harm.

Housing

There were times when mother was desperate for alternative accommodation. Mother's concerns and difficulties about housing had persisted between 2005 and 2009, even though she was provided with a two-bedroomed tenancy in 2007. Debt was a constant feature and source of stress.

Harassment – Risk assessment and classification

In October 2008 there were several alleged incidents of harassment by her ex-partner, the father of the older sibling. On the first occasion the police assessed the risk from the ex-partner as a standard risk. The review of the police action towards this harassment incident was that it should have been dealt with as a full offence of harassment and thereby rendering the ex-partner liable to arrest.

Harassment from the ex-partner continued and resulted in him being served with a Harassment Warning Notice, but there is nothing to indicate that the effect these episodes of harassment were having on mother and the children, was ever escalated for consideration by any agency.

Lack of professional curiosity and challenge

In September 2009, Child Y was taken to his GP's surgery to see the nurse practitioner for a routine vaccination appointment. It was noticed that the child had

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bruising across his forehead and cheek as well as a graze down his nose. Mother gave the explanation that Child Y had banged his head on the carpet and the bruising to his cheek had been caused by him falling asleep against the side of the cot bars. Child Y was 8 months old. The nurse practitioner was concerned and she raised the issue with a health visitor who confirmed that she should make a referral to social care which she did.

Within two hours of the referral a strategy discussion and a joint police and social care visit had taken place to the family home. The officer noted the injuries on a body map and despite reluctance from father 2, the parents were persuaded to take the child to hospital to be seen by a paediatrician.

There followed a medical examination by the paediatrician which assessed the injuries to have a plausible explanation. The paediatrician concluded that the injuries were consistent with the explanation given by the parents. The paediatrician did not compare the accounts that had been given by the parents to the police officer, the nurse practitioner and the social worker. There was no review strategy meeting which would have entailed a multi-agency risk assessment and an effective challenge of the paediatrician's decisions. There was a lack of professional curiosity by those involved, influenced by their perception of the doctor's seniority and experience.

As indicated in the Overview report a new Oxfordshire Safeguarding Children Board guidance introduced in March 2012 now stresses the proper processes to be adopted in these circumstances.

Recommendation (2)

OSCB to require all agencies involved in Section 47 investigations to jointly review and re-assess new information as it emerges throughout the investigation and have the ability to escalate concerns if necessary.

Missed opportunity

In June 2010 an anonymous referral was received by social care that Child Y had been seen with developmental delay and possibly bruising from falling over in the

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recent past. The referral was not dealt with in accordance with procedures and the child was not seen. A referral was made to the health visitor and a telephone call was made to mother, but there was no consideration for a full assessment and no written record of a referral. It appears the senior practitioner decided that the allegation did not require further social care assessment but there is no explanation of how he arrived at this conclusion.

The Children's Social Care service reported that at the time there were staffing issues within the department, which may have contributed towards this missed opportunity. The Overview report includes a reminder of practice for the agencies involved to ensure that anonymous referrals are taken as seriously as named referrals.

Signed agreement instigated by the police

Following the injuries of Child Y, an interagency strategy meeting was held at which the police requested to be informed of any intended communication amongst professionals about the case to ensure that the criminal investigation was not compromised. Those in attendance were asked to sign a document, which was outside of the safeguarding procedures and had unintended consequences. Social care staff members present were prevented from speaking to the parents of Child Y or anyone concerning the case. On examination of the signed document, it is clear that any restriction related to speaking about the events surrounding Child Y's death and not about generic care, support and other child protection issues. However the police's actions led to an unacceptable delay on the social worker's assessment of the protection and care of Child Y's sibling and a missed opportunity to follow up on an overheard remark by a friend of father 2 that could have contained incriminating evidence.

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The Independent Overview author has made the final generic recommendation:

Recommendation (3)

'The OSCB should ensure that a monitoring framework is in place to evidence and report on the progress of to the implementation of the recommendations

in this report; to monitor how Board agencies will evidence the impact of lessons learned from this Serious Case Review'

Finally, the Overview Report includes some history of the mother making allegations and complaints which had the effect of deflecting professional's focus from Child Y. Mention has been made in previous OSCB Serious Case Review Recommendations about dealing with parents who attempt to deflect attention away from the child(ren) which creates a risk of professionals losing sight of the child in the centre of the review.

Identified areas of good practice

The Independent Overview author recognised areas of good practice, namely the local Housing Authority assisting the mother to re-locate and to have improvements to her accommodation; Citizen's Advice Bureau and Floating Support assisting mother with her financial worries and tenancy issues. And finally in September 2009 the nurse practitioner appropriately referred Child Y to social care about her concerns regarding the bruising to Child Y. Social care instigated promptly a Section 47 joint investigation and used considerable skill to ensure Child Y was taken to hospital for a medical examination.

Conclusions

This is a tragic case of a 22 month old child dying from the most serious and horrific injuries. The mother was a vulnerable woman who suffered from harassment, had financial issues, and had at one time felt so low as to attempt suicide. Not all agencies were aware of all of these issues and as a result the impact on her capacity to parent her two young children, in conjunction with the father of the younger child, was not fully understood or used to lever in additional support.

There are common problems with this case in that communication and coordination between agencies could have been improved. This learning is reflected in the

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thematic report published by Ofsted in 2011[1] on lessons from serious case reviews'. The main messages are the importance of:

- carrying out assessments effectively
- ensuring that the necessary action takes place
- using all sources of information
- valuing challenge, supervision and scrutiny
- implementing effective multi-agency working
- focusing on good practice

This review has identified the following:

- **Carrying out assessments effectively: Quality of assessments**

Identifying the vulnerability of a mother with two children. She had previously attempted suicide and was struggling to cope with her own life, including financial, housing and harassment problems from her ex-partner.

- **Carrying out assessments effectively: Missed opportunities**

Mother's self-harming episode was a missed opportunity for a more coordinated response and improved information sharing between services, and for the welfare of the older sibling to be considered at the point of the emergency ambulance call out and subsequent A&E attendance. There was no assessment of the difficulties or strengths brought to the family by Child Y's father.

- **Carrying out assessments effectively: Keeping the focus on the child**

Mother had a history of making allegations and complaints which had the effect of deflecting professionals' focus from Child Y.

- **Using all sources of information: Thinking outside the box**

[1] 26 October 2011 Ofsted published a thematic report covering evaluations of 482 Serious Case Reviews carried out between by the inspection agency in England between 2007 and 2011 'Ages of concern: learning lessons from serious case reviews'

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There was a lack of 'thinking outside the box' and of taking the wider picture into account. There was an opportunity for professionals to assess more fully the impact of mother's previous history, relationship difficulties, housing, finance problems and emotional health on her parenting of the older sibling. This lack of a holistic view meant that there were missed opportunities to provide additional support to Mother, to both Mother and Father 2 together or to the children through early help services.

- **Ensuring that all necessary actions take place.**

In September 2009, there was a failure to hold a review strategy meeting, undertake a multi-agency risk assessment and take protective action of Child Y.

- **Valuing challenge: A lack of professional curiosity.**

In September 2009 there was a lack of professional curiosity by those involved in the assessment of injuries to Child Y. The paediatrician assessed the injuries to have a plausible explanation. The paediatrician did not compare the accounts that had been given by the parents to the police officer, the nurse practitioner and the social worker. There was no effective challenge of the paediatrician's decision.

- **Implementing effective multi agency working.**

The signed agreement instigated by the police was outside Oxfordshire Inter-agency Safeguarding Procedures. The actions of the police in this case deviated from the usual procedures of the Child Abuse Investigation Unit and affected the smooth implementation of the joint working following Child Y's final injuries.

If interagency enquiries and assessments had been more thorough at an earlier stage of family life when problems were first emerging it is likely that practice would have provided effective preventative support to Mother. Similarly if judgments had been more soundly reached and plans reviewed

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against objectives it is likely that interagency arrangements and processes could have better fulfilled their purposes.

In conclusion, taking all of the circumstances into account and looking at the whole history as presented by the IMRs of the agencies involved, whilst there are issues of concern, there is nothing to indicate that at any time either of the children should have been removed from their family. There were occasions however when Child Y should have been the subject of a multi-agency strategy meeting when bruising was seen or developmental delay reported. ' If the inter-agency safeguarding procedures in existence at the time had been followed after the first incident, it may have led to the child being placed on a child protection plan, which in turn, may have prevented the death of Child Y.

The cause of Child Y's injuries remains clouded with suspicion despite what the father has said. The fatal injuries suffered by Child Y were most likely to have been caused by trauma and more than likely intentionally caused; however the criminal investigation could not obtain sufficient criminal evidence for a prosecution other than that of neglect.

At a 'Finding of Fact' hearing it was found that father was the most likely perpetrator of the injuries as the Judge did not believe the father's given reasons for the injuries to be a truthful account. In May 2013 the father was prosecuted for a criminal charge of child neglect to which he pleaded guilty and received a fifteen month custodial sentence.

Oxford Safeguarding Children Board,
Final update to the report Nov 2013

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Recommendation (2)

OSCB to require all agencies involved in Section 47 investigations to jointly review and re-assess new information as it emerges throughout the investigation and have the ability to escalate concerns if necessary.

Recommendation (3)

The OSCB should ensure that a monitoring framework is in place to evidence and report on the progress of to the implementation of the recommendations in this report; to monitor how Board agencies will evidence the impact of lessons learned from this Serious Case Review.

Reminder of Practice

Children's Social Care to be reminded of the importance of recording details of anonymous referrals in accordance with existing procedures and ensuring the child is seen.

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