EXECUTIVE SUMMARY

SERIOUS CASE REVIEW
IN RESPECT OF A CHILD
Infant W

Chris Few

September 2012

INTRODUCTION

1.1 The Local Safeguarding Children Board Regulations, 2006 require Local Safeguarding Children Boards to undertake reviews of serious cases. Working Together to Safeguard Children (2010) provides statutory guidance on the criteria for holding such reviews and on how they should be conducted.

1.2 A Local Safeguarding Children Board should consider whether to conduct a Serious Case Review whenever a child sustains a potentially life threatening injury or serious and permanent impairment of physical and or mental health and development through abuse or neglect and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children.

1.3 The purpose of a Serious Case Review is to:

- Establish what lessons are lessons 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 inter-agency working and better safeguard and promote the welfare of children.

1.4 On 10 June 2010 the Secretary of State for Education issued amended guidance that all Serious Case Reviews commenced from that date should be published in full. That guidance was not however retrospective and this review was accordingly completed on the basis that only an executive summary will be published.

2 Summary of circumstances leading to the Review

2.1 In February 2010 Infant W was admitted to the local Hospital requiring resuscitation. Investigations identified that her condition was the result of brain and other injuries which are consistent with her having been shaken.

2.2 Infant W was discharged from hospital in February 2010 but it is believed she will have long term health issues as a consequence of her injuries. She is the subject of an Interim Care Order and is currently in a Local Authority foster placement.

2.3 At the time she sustained her injuries Infant W was the subject of a Child Protection Plan, intended to address concerns regarding the parenting ability of her parents.

2.4 The Serious Case Review sub-group of Oxfordshire Safeguarding Children Board (OSCB) considered the circumstances of Infant W's injuries on 18 February 2010 and recommended that a Serious Case Review be undertaken. That recommendation was endorsed by the Independent Chair of the OSCB on 25 February 2010.

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3 Terms of Reference

3.1 Draft Terms of Reference for this Review were developed by the Serious Case Review sub-group of the OSCB. These were subsequently reviewed and amended by the Serious Case Review Panel in light of information gathered during the Review.

3.2 The Review focused on Infant W. Her parents' status as children was however acknowledged and considered at all stages of the Review process.

3.3 The primary focus of the Review was from June 2008, when Infant W's mother was accommodated in a Local Authority Children's Home, until 48 hours after Infant W's admission to hospital in February 2010. Significant events in the childhood of both parents were also taken into account in order to provide some understanding of their backgrounds and the development of their relationship.

3.4 Within the Terms of Reference a number of specific issues to be addressed were identified:

- Were race, religion, language, linguistic and cultural needs met during the intervention with the family, by all agencies; to include learning disabilities and or any mental health issues
- Were the assessments and support to the two teenage parents and family members sufficient, taking into account their backgrounds, risk factors and situation
- Were there recorded references to the grandparents of Infant W suffering domestic abuse, mental ill health or misusing substances, and any such records relating for Infant W's parents
- Was pre-birth assessment and planning undertaken in a timely way, did Infant W's premature delivery have a significant impact on this and did services respond appropriately, in line with contingency plans
- Were Infant W's parents' pre/post birth mental health needs adequately identified and addressed
- What factors influenced a change in planning from a supervised mother and baby placement to Infant W living in a guest house with her father
- Were Infant W's needs central to the assessment and planning process
- Was the impact of the Infant W's parents' volatile relationship sufficiently considered in planning and service delivery
- If up to date medical information had been available at a Review Child Protection Conference in February 2010 would the decision and plan have been markedly different.

3.5 In addressing these questions the Review also considered the specific issues identified at paragraph 8.39 of Working Together to Safeguard Children, 2010.

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4 Serious Case Review Panel

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

4.2 Chris Few, an independent consultant, was appointed to write the Overview Report at the outset of the Serious Case Review. He had previously conducted an agency management review for Oxfordshire County Council Education Services and authored the Overview Report of another Serious Case Review in Oxfordshire but otherwise has no personal or professional connection with any agency in the County.

4.3 Other members of the Serious Case Review Panel were:

- Lead Solicitor - Oxfordshire County Council
- Superintendent - Thames Valley Police
- Designated Nurse - Oxfordshire Primary Care Trust
- Lead Officer Safeguarding - Oxfordshire County Council Children, Young People and Families Service
- Assistant Delivery Director – Connexions
- Interim Service Manager - Youth Offending Service
- Business Manager - Oxfordshire Safeguarding Children Board.

5 Review process

5.1 The Serious Case Review Panel met on seven occasions to consider the agency management reviews and progress the Serious Case Review.

5.2 The Panel agreed that meeting with family members was important to gain a full understanding of their situation as children and new parents; and of Infant W's life prior to her being injured. The parents had however been arrested and were on bail whilst the circumstances of Infant W's injury were investigated. It was recognised that interviewing the parents prematurely could interfere with the integrity of that investigation and any consequent prosecution. A decision on the timing of an offer to meet with the Independent Author and for completion of the Review was therefore deferred.

5.3 In this connection an extended timescale for the Review was agreed by the Serious Case Review Panel and notified to the Government Office for the South East (GOSE) and subsequently Ofsted.

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

5.5 The Serious Case Review Overview Report was presented to, and accepted by, the Oxfordshire Safeguarding Children Board on 20 September 2012.

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6 Contributions to the Review

6.1 Individual Management Reviews (IMRs) were received from:

- Community Health Oxfordshire
- Connexions
- Oxford Radcliffe Hospitals NHS Trust
- Oxfordshire County Council – Children, Young People and Families Service
- Oxfordshire County Council - Education Services
- Oxfordshire County Council - Legal Services
- Thames Valley Police
- Oxfordshire Youth Offending Service.

6.2 In addition to the Individual Management Reviews, an Overview of the health agencies' involvement was prepared by the Designated Nurse for Oxfordshire PCT in accordance with Working Together to Safeguard Children 2010.

6.3 These were supplemented by:

- Relevant research and inspection reports
- Policy and guidance documents
- Copies of documents, meeting records and communications
- Judgements of the High Court of Justice
- Correspondence with individuals and agencies to confirm and clarify information.

7 Family engagement

7.1 The parents of Infant W were notified that this Serious Case Review was being conducted and the process was explained in a face to face meeting with Infant W's Social Worker.

7.2 Following their conviction, letters were hand delivered to both parents inviting them to contribute to the Review. Unfortunately neither wished to do so. The Review therefore had to be concluded without their perspective on the events prior to Infant W being injured.

7.3 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 INJURY OF Infant W

8.1 Infant W and her parents are white British and from English speaking families.

8.2 Infant W's mother, who was under 18 in February 2010, had been known to Children's Social Care from the age of nine in connection with care arrangements following the death of her mother. From her early teenage years she had been a Looked After Child in the care of Oxfordshire County Council and shortly after became a Looked After Child in a Local Authority residential home. She had had contact with a number of other agencies in Oxfordshire, mainly in relation to her Looked After Child status, going missing from care and absence from education.

8.3 Infant W's father was under 18 years of age in February 2010. From pre-school age onwards he had had extensive involvement with a number of agencies in Oxfordshire. This was in connection with abuse and neglect within his family, a problematic education, offending behaviour during his teenage years and homelessness.

8.4 Assessment of Infant W's future needs and planning for her care commenced during her mother's pregnancy. Professional plans centred on Infant W and her mother being accommodated in a mother and baby foster placement. No placement that was suitable and acceptable to the parents was however identified and, following her birth, Infant W was cared for by her father at the home of his father and stepmother.

8.5 When Infant W was aged four weeks she was made subject of a Child Protection Plan, intended to address concerns regarding the parenting ability of her parents.

8.6 The family accommodation arrangement for Infant W and her father ended and they moved to a guest house shortly before the admission to the Local Hospital. This was an interim arrangement pending supported independent accommodation becoming available. Throughout this period Infant W was visited daily by her mother, although her father was the main caregiver.

8.7 In February 2010 Infant W was admitted to the local Hospital requiring resuscitation. Investigations identified that her condition was the result of brain and other injuries consistent with her having been shaken on two occasions separated by a period of 2-3 weeks.

8.8 Infant W was discharged from hospital in February 2010 but it is believed she will have long term health issues as a consequence of her injuries. She is currently in care of the Local Authority.

8.9 On 24 July 2012 Infant W's parents were convicted at Oxford Crown Court of offences committed against Infant W; her father of two counts of inflicting grievous bodily harm with intent, and both parents one count of child cruelty. Both were sentenced on 28 August 2012 with Infant W's father receiving three years in a Young Offenders Institution and her mother a 6 month community sentence.

LEARNING FROM THE REVIEW

9.1 The Serious Case Review identified a number of key themes which, along with the need for greater professional knowledge of legislation and associated powers, constitute the learning from this review:

- Blurred practice boundaries
- Assessment quality
- Core Group effectiveness
- Support provision for teenage parents
- The role of fathers.

9.2 Whilst expressed individually these themes are in many ways interdependent and all contributed to professional involvement with the family being less effective than it should have been.

9.3 These themes echo the recurring issues in professional responses to vulnerable babies and their families identified in the 2011 Ofsted analysis of Serious Case Reviews[1], including those concerning babies under one year old[2].

[1] Ages of Concern: learning lessons from serious case reviews (110080), Ofsted, 2011.
[2] Babies under one year old comprised 210 (35%) of the 602 children subject of serious case reviews during this period.

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10 Blurred practice boundaries

10.1 Blurring of practice boundaries arising from professionals, particularly within Children's Social Care, attempting to work in the best interests of Infant W's mother as a looked after Child and simultaneously in the best interests of Infant W were evident throughout the period under review.

10.2 Early in the pregnancy of Infant W's mother it was decided that her own Social Worker would undertake the pre-birth assessment in respect of her unborn child. As the pregnancy progressed the mother's own overwhelming level of need and inconsistency with professionals led to the focus on Infant W's interests being largely eclipsed. Following Infant W's birth, adoption of the main carer role by her father introduced a further set of competing needs, adding to the distraction away from a primary focus on Infant W.

10.3 Further difficulty arose when the views of and decisions made by Infant W's mother as a (prospective) parent conflicted with the plans seen as necessary by Children's Social Care in exercising their role as her corporate parents. This manifested as moves towards using child protection processes in respect of Infant W and sanctions which would impact on the parenting role of Infant W's mother as a means of securing her compliance. This questionable practice was met with resistance and disengagement.

10.4 To address these issues the Review made two recommendations:

10.5 ***That Children's Social Care, in consultation with partner agencies, should produce professional practice guidance for situations where both parents and their (unborn) children are (prospective) service users and in particular where corporate parenting responsibilities exist. This should enable professional networks to identify case specific practice boundaries and arrangements for coordinating work across these.***

10.6 ***That Children's Social Care should ensure that needs and service provision for parents and their children, where both are service users, are assessed and managed by separate Social Workers. This applies equally to the assessment and any consequent processes in respect of unborn babies.***

10.7 Initial and Review Child Protection Conferences held in respect of Infant W were chaired by the Independent Reviewing Officer responsible for her mother. This undermined the independence of the chair, and thereby the objectivity of the conferences. The chair's familiarity with information relevant to the conferences also led to this not being comprehensively elicited from attendees to inform decision making. The most serious consequence of this was an over emphasis in Child Protection Plans on issues connected with the parents, to the detriment of measures focussing primarily on the protection and welfare of Infant W.

10.8 In relation to this issue the Review recommended:

10.9 ***That Children's Social Care ensure that Child Protection Conferences in relation to the children of a Looked After Child are not chaired by the Independent Reviewing Officer responsible for the parent, who should contribute to the conference as an attendee or through provision of a report.***

11 Assessment quality

11.1 It was apparent from the start of the pregnancy of Infant W's mother that, consequent to the support needs of the parents, their baby would be a Child in Need. The primary assessment tool for planning services to support the parenting of Infant W was therefore a pre-birth assessment. This assessment process was deficient in a number of respects.

11.2 The assessment was not commenced until 21 weeks after Infant W's mother was confirmed to be pregnant and then completed only five days prior to the birth of Infant W. The potential for plans arising from the assessment to be effectively implemented was therefore seriously undermined.

11.3 The pre-birth assessment was conducted by a Social Worker who had no experience of such assessments and compiled on a computerised Initial Assessment format. This undermined the depth of analysis and the quality of the subsequent planning processes.

11.4 There was a narrow focus on a mother and baby foster placement as the preferred option for Infant W's care and insufficient consideration of the role of her father within assessment and planning processes. The assessment did not consider any of the other potential care options or provide contingency plans against the possibility that a suitable mother and baby placement would be either unavailable or unacceptable to Infant W's parents.

11.5 During her pregnancy Infant W's mother was subject of a number of parallel planning processes. There is no indication that these processes were effectively coordinated with each other or the pre-birth assessment beyond the involvement of the same professionals in a number of the different strands. A number of key professionals were not engaged in contributing to the assessment.

11.6 Subsequent Children's Social Care assessments were also flawed and lacked responsiveness to changed circumstances and new information.

11.7 Assessment quality in the case of Infant W was suggested by the staff interviews undertaken to be a wider concern. This was addressed by a recommendation of the Children's Social Care IMR. However, taking into account that deficiencies in the assessments were not identified or addressed by Children's Social Care management, the Review recommended:

11.8 ***That Children's Social Care ensure that rigorous and continuous arrangements for monitoring the quality of assessments are in place and that there is regular exception reporting of both this monitoring activity and its findings to the Director for Children's Services. The outcomes of this process should be included within the Oxfordshire Safeguarding Children Board performance framework.***

12 Core Group effectiveness

12.1 The Core Group has a key role in development and implementation of an effective Child Protection Plan. In this case the Core Group did not fulfil this function and a numbers of deficiencies in its operation were evident:

- Poor organisation and coordination
- Lack of engagement by agencies other than Children's Social Care
- Poor communication and information sharing
- Lack of progress monitoring
- Absence of challenge regarding the effectiveness of the Core Group

12.2 Action has been taken in Oxfordshire to improve Core Group effectiveness consequent to a previous Serious Case Review (Children D, E, F & G 2009). The deficiencies in this case occurred however after the action plan arising from the earlier review had at least started to be implemented. Investigating the underlying causes of this difficultly would therefore be appropriate; alongside the existing audit, training and practice guidance developments.

12.3 Adopting this approach, the Review recommended:

12.4 ***That the Oxfordshire Safeguarding Children Board commission its QAA subgroup to engage with professionals across all relevant agencies, identify barriers to effective Core Group engagement and operation, and report on ways to address these.***

13 Support provision for teenage parents

13.1 The Health Overview Report identified that while maternity provision for Infant W's mother followed the Oxford Radcliffe Hospitals NHS Trust Teenage Pregnancy Pathway (2005) this actually mitigated against effective information sharing and cooperation between those providing midwifery care and other professionals.

13.2 It is therefore appropriate that both this Teenage Pregnancy Pathway and the wider Oxfordshire Teenage Pregnancy Strategy have been reviewed and updated, as part of the Oxfordshire Children and Young People's Trust "Narrowing the Gaps" agenda, to provide an holistic package of care which includes:

- Access to Healthy Start
- Contraception and Sexual Health advice
- Support for parenting (Including the Family Nurse Partnership)
- Targeted support through the Healthy Child Programme
- Support for employment, education or training
- Strong partnerships between services e.g. Maternity, Universal Services, Children's Centres, Connexions.

13.3 In the above circumstances the Review made no recommendation in respect of services to teenage parents.

14 The role of fathers

14.1 Infant W's father was not mentioned once in any of the midwifery pre-birth documentation. The situation was somewhat better within Children's Social Care where his need to be involved in Infant W's life was recognised. Infant W's father was not however considered as having an equal parental role to her mother, reflecting a cultural professional mindset in which the father was seen as almost irrelevant, or at best incidental, to Infant W's parenting.

14.2 As a consequence the potential for the unborn baby to be cared for within her father's extended family was never effectively explored. The parents' decision that Infant W's father would undertake the primary carer role therefore seemed to come as a complete surprise to professionals; resulting in an unplanned, uncoordinated and rushed response.

14.3 Within this the most serious deficit was that prior to Infant W's discharge from hospital her father had had no education or support to prepare him for a role in the care of his baby.

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14.4 Even subsequently, the primary carer role of Infant W's father was seen as a substitute arrangement until her mother could assume that role. Thus resulted, for example, in the primary birth visit of the Health Visitor being undertaken at a Children's Centre, rather than at the father's address.

14.5 Whilst a father adopting a primary carer role for a newborn child is undoubtedly unusual it is not unique; and even in situations where the mother provides the majority of care many fathers play a significant role in parenting their children. It is therefore important that professional practice recognises this and ensures that both parents are supported in the role that they undertake.

14.6 Addressing an entrenched mindset is not easy. It may however be influenced by the strategic and practice framework within which professionals work. In this regard the Review recommended:

14.7 ***That the Oxfordshire Health and Wellbeing Board should ensure that the Teenage Pregnancy Strategy appropriately reflects and addresses the support needs of fathers and other male caregivers.***

14.8 ***That the Oxfordshire Safeguarding Children Board and its partner agencies include within their training provision relating to the assessment of children and their families an emphasis on including information regarding, and planning for the involvement of, men within the family.***

14.9 ***That the QAA sub group of the Oxfordshire Safeguarding Children Board include within their arrangements for monitoring and reporting on the quality of assessments and other practice, consideration of how effectively the presence and role of fathers and males within families has been addressed.***

15 Other Learning - Professional knowledge of legislation and powers

15.1 Whilst not impacting on the outcome of events there were a number of occasions during the period covered by this Review where Police, Health Trust and Children's Social Care professionals demonstrated a less than robust knowledge of the law within which they were operating. This related particularly to the legal status of and parental responsibility for children; and the powers available to professionals to intervene to safeguard a child.

15.2 The Review recommended:

15.3 ***That the Oxfordshire Safeguarding Children Board commission and include on their website a comprehensive lay person's guide to the legislative framework within which professionals operate when safeguarding children.***

16 Learning from the Individual Management Reviews

16.1 The IMRs which contributed to this Review identified and made recommendations in relation to a number of other areas where services should be improved. In some cases the background circumstances fall outside the scope of this Review. The learning is nonetheless important. These include:

- Provision of education services to Looked After Children and young people with Special Educational Needs
- Coordination and engagement of education support and youth offending services with child protection arrangements

- Provision of primary health care services to Looked After Children
- Midwifery and Health Visiting provision for vulnerable children and families
- Engagement of escalation procedures by health professionals
- Case recording practices
- Provision of IAG[3] (Connexions) services to vulnerable young people
- Assessment and management of infants at hospital emergency departments
- Return interviews for missing children, and particularly those in residential care
- Police attendance at Child Protection Conferences
- Arrangements for provision of legal advice to Social Workers, including in relation to pregnant teenagers who are looked after or known to Children's Social Care
- Safeguarding children awareness by ambulance service personnel.

17 Areas of Good Practice

17.1 A number of professionals demonstrated commendable commitment and perseverance in providing services to both of Infant W's parents, often in the face of disengagement and resistance. These included, in particular, a Youth Offending Service Intensive Support and Supervision Officer and a Housing Support worker engaged with Infant W's father as well as a Specialist Nurse for Looked After Children and a Community Midwife for Infant W's mother.

17.2 Conducting Looked After Child Reviews, and associated health reviews, is not a statutory requirement for children in private fostering arrangements. That these processes were utilised for Infant W's mother when in such an arrangement that was supported by the Local Authority is however considered to be safe and effective practice.

CONCLUSION

18.1 The events leading to this Serious Case Review comprise a sad story of two damaged and vulnerable young people who came together in an intense but apparently enduring relationship and had a child together.

18.2 All indications are that Infant W's mother and father were both loving and committed parents. There was at no point prior to Infant W's presentation at hospital in February 2010 any suggestion that either parent intended to deliberately harm their child.

18.3 Even with the benefit of the hindsight applied by this Serious Case Review process and the parallel Family Court and criminal proceedings there is no indication that there was an intention to cause Infant W serious harm. It is typical that injuries of the type sustained by Infant W result from a momentary loss of control when the person responsible is alone, stressed, tired, frustrated and unable to cope with the persistent demands of a crying baby. That the perpetrator loves and cares for the child is immaterial.

18.4 It could and should however have been identified that the circumstances into which she was born and in which she was cared for created an environment in which there was a significant potential for such a sudden reaction or outburst by either parent to cause her physical harm. The age of Infant W's parents, their troubled histories, unresolved issues of loss, inadequate living arrangements and social isolation could all be seen as increasing the stresses that would be placed on them.

[3] Information, Advice and Guidance.

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18.5 Recognising this risk of physical harm would not have changed the underlying approach of the assessments and plans made; to support Infant W's mother and father to effectively and safely parent Infant W in a suitable environment. It would certainly have been unreasonable to expect this to have led professionals to conclude that Infant W should be removed from her parents care, or provided the basis for doing so. It should however have properly increased the focus of plans, in their development and implementation, on the safety of Infant W; whilst ensuing that the parents were robustly supported in their parenting and highlighted the need for appropriate respite arrangements.

RECOMMENDATIONS

19.1 The Review made nine recommendations as outlined in sections 10-15 above.

19.2 The implementation of recommendations from both the Individual Management Reports and the Overview Report are the subject of action plans developed by the Oxfordshire Safeguarding Children Board. Progress with these is reported to that Board via the Quality Assurance and Audit subgroup.

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