Executive Summary of Serious Case Review

Child T
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1. Circumstances of the Review

This Serious Case Review was commissioned by Rotherham Safeguarding Children Board following the unexpected death of an eleven day old infant whilst in the care of her mother. Whilst the child’s post-mortem concluded that this was a sudden unexpected death in infancy, she had been made the subject of a Child Protection Plan in the category of physical abuse at birth and her two siblings had been the subjects of Child Protection Plans since November 2007 in the category of emotional abuse. Prior to the child’s birth, the family had either current or historical involvement with a number of agencies, all of which provided Individual Management Reviews.

The review was commissioned in accordance with the Local Safeguarding Children Boards Regulations (2006) and Chapter 8 of “Working Together to Safeguard Children” (2006). The review covers the period from 1996 to August 2008.

2. Purpose of the Serious Case Review and Terms of Reference

Serious Case Reviews should always be conducted when a child dies and abuse or neglect is known or suspected to be a factor in the death.

The purpose of this Serious Case Review is to establish what happened, whether information was shared fully by those professionals involved and procedures were appropriately followed, so that any loopholes can be closed and lessons learned to minimise a possible repeat for another child. This should also reassure the public and prevent the need or demand for further external inquiries.

Agencies were required to review all relevant records in respect of both Child T’s parents and all three children from 1996 to 28th August 2008. This was to include the date when Child T died and Police involvement immediately afterwards. A full chronology detailing the work of staff of each relevant agency was provided.

Agencies were requested to examine:-

- Inter-agency working and communication between the agencies involved.
- Consider whether the decisions and actions taken by the agencies involved were in accordance with policies, procedures and relevant practice standards.
- The quality of assessments and decisions made, particularly in the context of evidence of alcohol/substance misuse/domestic violence in the home.
- The effectiveness of the child protection conference system and core group meetings.
• The quality of discharge planning from hospital for Child T, child protection planning for Child T and her siblings, and professional responses to alcohol misuse and domestic violence in the home.

• The management and supervision of staff and the support provided in working with a child protection case in relation to their level of knowledge and experience.

• Any discussions around the threshold for legal action in respect of the children.

• Any similarities with previous Serious Case Reviews and their recommendations and subsequent actions.

Agencies were required to make recommendations in respect of any lessons to be drawn from this case and any appropriate action to improve future practice in the light of the review findings.

3. The Independent Author of the Overview Report

The Author of this Overview Report has been working at the Independent Bar since 1998. Her practice was based largely in criminal law with some family law until 2001, when she began developing a practice in family law with particular emphasis on public law. She continues to practice in Criminal and Family Law, including all types of crime, both prosecution and defence. The majority of her practice currently is care work and she is involved in providing training for other members of the Bar, Solicitors, Social Workers, Local Authority Lawyers and the Police through Chambers and the local Family Court Forum. She is a member of the Family Law Bar Association, Criminal Bar Association, local Family Justice Council, Sheffield Court Users’ Group and the newly formed Northern Administrative Law Association and is also a trustee of a local women’s hostel. Her appointment is in accordance with the guidance at 8.20 Chapter 8 of ‘Working Together to Safeguard Children’ in that she is independent of Rotherham Safeguarding Children Board and all the agencies/professionals involved.

4. Agency Involvement and Reports

The Serious Case Review Panel comprised representatives from:

• RMBC Children and Young People’s Services
• National Probation Service
• NHS Rotherham
• Rotherham NHS Foundation Trust
• Rotherham, Doncaster and South Humber NHS Mental Health Foundation Trust
• South Yorkshire Police
• RMBC Neighbourhoods and Adult Services

The Panel had the Rotherham Safeguarding Children Board Manager as a professional adviser and a senior RMBC Service Solicitor, Children and Young People’s Services, as a legal adviser.
The Panel received and considered Individual Management Reviews from:-

- RMBC Social Care
- NHS Rotherham Community Health Services
- Rotherham NHS Foundation Trust
- Rotherham, Doncaster and South Humber NHS Mental Health Foundation Trust
- South Yorkshire Police
- Neighbourhood and Adult Services/2010 Rotherham Ltd.
- Action Housing
- National Probation Service
- RMBC Education Services/Early Years and Childcare

5. Family Composition:

Child T (subject child)
Sibling 1
Sibling 2
Mother
Father
Maternal grandmother
Maternal step grandfather

6. Summary of the Case

Child T was born in August, 2008, and was discharged from hospital two days later, following a pre-discharge planning meeting, into the care of her mother.

Eleven days after her birth, the infant’s mother called the emergency services at 5.30am having found her child pale, floppy and not breathing in bed beside her. She was transferred to hospital where attempts to resuscitate her were unsuccessful and she was pronounced dead later that same morning.

On the previous day the mother, who had a history of alcohol misuse, had been present at a family barbecue during the afternoon at which time she had consumed an amount of alcohol.

A post-mortem gave the cause of death as “sudden unexpected death in infancy”. She was reported to be a well cared for baby and there were no suspicious findings. However, co-sleeping is identified as a recognised risk factor for sudden infant death. This can involve accidental overlaying and/or alteration in the baby’s body temperature. The risk of overlaying is increased if the adult is alcohol or drug intoxicated.

The mother was initially arrested for the offence of “causing or allowing the death of a child” contrary to Section 5 of the Domestic Violence, Crime and Victims Act 2004 but not charged as the Crown Prosecution Service took the view that there was insufficient evidence to support a prosecution. The mother
reported that the child's father had had no contact with the child on the day of her death.

The couple had met in 2003 when they were both 19 and had periods when they lived together. Although they had three children, Child T’s father was never willing to engage in child protection conferences and health planning either for himself or for his children.

The couple's first two children were both subject to Child Protection Plans following the mother’s arrest in November 2007 due to her being under the influence of alcohol while the children were in her care. During each pregnancy the mother was drinking and was subjected to domestic violence from the children’s father. She was involved in violent altercations with her mother, step-father and neighbours.

Once the children were born, they were exposed to the behaviours described above with the consequent risk of significant emotional and physical harm that is probable in such families, where there has been no successful intervention.

Ahead of Child T’s birth it was decided that she should be subject to a Child Protection Plan at birth in the category of Physical Abuse.

There was inadequate information sharing between agencies involved with the family and child protection procedures should have been invoked earlier than they were. A number of serious incidents were not notified to Social Care and on occasions when referrals were received, they were not acted upon in a timely or appropriate manner.

Child T died on 25th August in the circumstances outlined above.

7. Key Learning Points

- All professionals need to use constructive challenge consistently both when working with parents and each other. Failure to do so results in issues remaining unaddressed with consequent unassessed risk.
- All agencies did not identify adequately the risks to which the children were exposed and the impact of alcohol abuse and domestic violence was seriously underestimated.
- The impact of living with the impact of alcohol abuse and domestic violence would benefit from further research both nationally and locally.
- Identification of risk factors followed by critical analysis of available information is crucial to the safeguarding of vulnerable children. This requires all agencies to share information in a timely manner and to keep at the forefront of assessments the knowledge that not all parents engage openly and honestly with professionals. Maintaining ‘respectful uncertainty’ (Laming 2003) should be a key feature when working with families where there are concerns about children.
- All services that have contact with children need to be mindful of the fragility of life in the early years and the absolute dependence infants have on those who care for them.
8. Recommendations for Child T SCR

The Serious Case Review Panel and Overview Author have accepted all the recommendations within the Individual Management Reviews. There are five additional recommendations which apply to the Safeguarding Children Board which were proposed and/or agreed by the Serious Case Review Panel and the Overview Author:

**Recommendations to NHS Rotherham Community Health Services**
*(Recommendations from the IMR)*

1. The Head of Children and Young People’s Services (C&YPS), Rotherham Community Health Service (RCHS), will ensure that systems are in place to allow all newly qualified Health Visitors and those employed from other trusts to access the support of a preceptor and local mentor by May 2009. This process will be audited by the Practice Standard Managers in March 2010 and results discussed at the Safeguarding Children health forum.

2. The RCHS, Head of C&YPS will ensure, by September 2009, that Health Visiting students and Health Visitors employed from other trusts understand their responsibilities in relation to child protection and safeguarding, and are trained and competent to manage child protection cases before they are allocated. This will include how to respond when families are not complying with child protection agreements/plans.

3. The RCHS Head of C&YPS will ensure with immediate effect (May 2009) that the process for the management of ‘vacant’ caseloads is clarified and disseminated. This should be viewed in line with capacity and demand issues including annual leave, maternity leave and prolonged sickness.

4. The RCHS, Head of C&YPS will ensure by September 2009, that an audit of the quality of Health Visiting assessments and compliance with the ‘No Access’ Procedure is completed and that these checks are repeated annually as part of the records keeping audit. Findings are to be responded to with recommendations for improvement.

**Recommendations to Rotherham Foundation Trust**
*(Recommendations from the IMR)*

5. The Medical Director of the RFT will ensure, by 30th June, 2009, that there is adequate documentation of Community Midwifery booking information, mental health issues, Social Care involvement and outcomes of Police investigation in mother’s antenatal notes.

6. The Medical Director of the RFT will ensure, by 31st October, 2009, that there is a system of communication of antenatal safeguarding information, such as parental mental health issues, alcohol misuse, domestic violence, Social Care involvement and antenatal child protection conferences, discussions and meetings in the baby notes.
Recommendations to South Yorkshire Police  
(Recommendations from the IMR)

7. The District commanders for each of the policing districts of South Yorkshire Police to ensure that the historic paper records relating to child protection concerns are converted on to the CATS system by 1st July 2009.

8. The Manager of the PPU at Headquarters to ensure that the training currently delivered to Call Handlers, front line officers, civilian investigators and Police Community Support Officers is fit for purpose. Ensuring that it includes amendments to and policy in all areas of Public Protection work; the importance of record keeping and the need for staff/officers to be child focussed in accordance with their Sec 11 responsibilities. To be implemented by 1st December 2009.

Recommendations to Children and Young People’s Services Social Care  
(Recommendations from the IMR)

9. The Director of Locality Services should ensure that Social Care training is reviewed by July 2009 to ensure the delivery in 2009/2010 includes:-
   - Children affected by domestic abuse.
   - Assessment and working with alcohol/drug using parents.
   - Training for Team Managers on thresholds for Initial and Core Assessments and Section 47 with particular reference to domestic violence and drug/alcohol abuse.

10. The Director of Locality Services should instruct Team Managers in writing to respond to any SYP Notification of Child Concern by giving explicit consideration to a Sect 47 investigation. Any notification should be followed up, on receipt, with a telephone discussion with SYP.

11. The Director of Locality Services should re-issue the instruction that Social Workers complete a chronology for every open Child in Need, Child Protection, and Looked After Child case by August 2009, and that chronologies and case recording should always indicate when a child is seen and spoken to. This instruction should be audited by Team Managers and Locality Managers in a themed audit in October 2009, and reported back to the Director of Locality Services.

12. The Director of Locality Services should commission a business process re-engineering examination of the receipt of Domestic Violence reports from SYP by C&YPS, to include responsibility for inputting onto SWIFT. This should be October 2009.

Recommendations to National Probation Service  
(Recommendations from the IMR)

13. The responsible manager should ensure by May 2009 that the practice instruction on risk assessment is revised to reflect the national offender
assessment system guidance, to ensure accurate and comprehensive assessment of Risk of Harm.

14. The Head of Rotherham Local Delivery Unit should ensure by September 2009 Risk of Harm is regularly reviewed in all cases (including those classified as Tier 1) and ongoing planning in all cases accurately reflects the Risk of Harm to others, particularly in respect of children, prisoners and staff.

15. The Head of Rotherham Local Delivery Unit should ensure by September 2009 an increased focus is given to child safeguarding issues through raising staff awareness of their responsibilities, increasing management oversight of relevant cases and engaging effectively with Rotherham Local Safeguarding Children Board.

Recommendations to Neighbourhoods and Adult Services and 2010 Rotherham Ltd.
(Recommendations from the IMR)

16. The Directors of Neighbourhoods and Adult Services and 2010 Rotherham Ltd will ensure by 31st December 2009 that all visiting staff in 2010 Rotherham Ltd and Neighbourhoods and Adult Services attend mandatory training regarding Safeguarding Children.

17. The Directors of Neighbourhoods and Adult Services and 2010 Rotherham Ltd will ensure by 31st December 2009 that referral systems regarding safeguarding issues are in place to other agencies.

Recommendations to Action Housing
(Recommendations from the IMR)

18. The Chief Executive of Action Housing is to ensure by 30th September 2009 that all processes with regard to Action Housing in the Rotherham area around safeguarding children are fit for purpose. An audit of this recommendation will take place in March 2010.

19. The Chief Executive will ensure that a training needs analysis for safeguarding children is completed by 30 March 2009, and that plans are put in place to address identified training needs by 30 March 2010.

Recommendations to Inclusion Services
(Recommendations from the IMR)

20. That the Director of Inclusion Services will ensure that guidance in relation to information sharing is re-circulated to all schools and educational settings by April 2009.
21. The Independent Chair of Rotherham Safeguarding Children Board should, by 21 August 2009, seek assurance from the Director of Children’s Services that by 30 September 2009, a procedure is in place which requires core group notes to be distributed within 10 working days of meetings.

22. The Independent Chair of Rotherham Safeguarding Children Board should by 21 August 2009 require all partner agencies to demonstrate that they have in place guidance that requires the child’s perspective to be taken into account in all risk assessments.

23. The Independent Chair of Rotherham Safeguarding Children Board should, by 21 August 2009, commission a multi-agency review of safeguarding children training to ensure there are learning objectives (for all agencies who work with children, young people and their families) around constructive challenge and ‘respectful uncertainty’ (Laming 2003) where parenting may be compromised. The review should be undertaken by the Safeguarding Children Operational Unit by September 2009 and results reported to the Rotherham Safeguarding Children Board Training Sub-Committee in October 2009.

24. The Independent Chair of Rotherham Safeguarding Children Board should ensure, by 31st October 2009, that the revised procedure “Safeguarding of Children of Drug/Alcohol Misusing Parents/Carers” (agreed by RSCB on 31st July 2009) is launched and disseminated on a multi-agency basis.

25. The Independent Chair of Rotherham Safeguarding Children Board should, by 30th September, 2009, commission the Operational Safeguarding Unit to deliver training to GP practices in relation to the “Safeguarding of Children of Drug/Alcohol Misusing Parents/Carers” policy.

This Executive Summary was written by Steve Pearson, Communications Manager, Children and Young People’s Services, in consultation with Pennie Stanistreet, Independent Overview Author, and Catherine Hall, Interim Safeguarding Children Board Manager.

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