CHILD D

A SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

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On behalf of the Havering Local Safeguarding Children Board
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1. INTRODUCTION

1.1 The London Ambulance Service was called to an address in the London Borough of Havering in July 2010, in the early hours of the morning. They found Child D, who was nearly 6 months old, showing no signs of life. There were indications that he had been dead for some hours. His father, Mr E, had just returned from work. His mother, Ms F, was unwell and required medical treatment.

1.2 The circumstances of the death of Child D led the Havering Safeguarding Children Board (HSCB) to conduct a Serious Case Review (SCR) in line with statutory requirements, as set out in the government's guidance[1].

1.3 This is the anonymised Executive Summary of the Overview Report arising from that Serious Case Review. This report contains

- An account of the reasons for conducting the review and its process
- A summary of the key events
- A summary of the findings and lessons to be learnt from the Serious Case Review

2. DECISION TO CONDUCT THE SERIOUS CASE REVIEW

2.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Boards to undertake reviews of serious cases. The Regulation defines a serious case as one where
(a) abuse or neglect of a child is known or suspected; and
(b) either –
(i) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

2.2 In this case, the decision to conduct a SCR was based on the death of a child in circumstances giving cause for concern that he had been neglected. The key issues identified as indicating that a SCR was necessary were:

- the period of time that elapsed before emergency services were contacted.
- the presentation of the child when found by emergency services.
- the presentation of the mother when emergency services attended.
- there had been significant contact between the family and some local services before the death of Child D.

2.3 The purposes of SCRs are set out in "Working Together" (Paragraph 8.5). They are to

[1] Working Together to Safeguard Children (2010) – referred to in this report as "Working Together"

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

2.4It was determined that the following agencies should contribute to the Review:

AGENCY	**NATURE OF CONTRIBUTION**
Barking Havering and Redbridge University Hospitals NHS Trust (BHRUT)	Individual Management Review
North East London NHS Foundation Trust (NELFT)	Individual Management Review
Outer North East London Community Service (ONEL CS)	Individual Management Review
London Ambulance Services NHS Trust (LAS)	Individual Management Review
London Borough of Havering, Social Care and Learning – Children and Young People Services (CYPS)	Individual Management Review
Metropolitan Police Service (MPS)	Individual Management Review
NHS Havering	Health Overview Report[2]

2.5 Individual Management Reviews (IMRs) and the Health Overview Report were drawn up by officers who had had no previous involvement in the case. The parents of Child D did not respond to invitations to participate in or contribute to the Review.

2.6 A Panel was established to manage and assure the quality of the review process. In order to provide impartial leadership and appropriate challenge, the Panel was chaired by Ms Sue Dunstall. Ms Dunstall formerly chaired Northamptonshire Area Child Protection Committee. She was a non-executive director of Northampton General Hospital Acute Trust (1997-2005); and an elected member of Northampton Borough Council (1995-1999) and Northamptonshire County Council (1997-2001). She currently holds a substantive part-time post as policy advisor with the NSPCC, alongside which she acts in an independent capacity as Chairperson of the Havering LSCB.

2.7 The composition of the Panel was as follows:

[2] "Working Together", Para 8.30, requires that all SCRs should include "an integrated health chronology and a health overview report focusing on how health organisations have interacted together".

Name / Designation	Organisation	Role
Ms Sue Dunstall	Independent	Independent Chair
Service Manager	North East London Foundation Trust	Panel Member
Interim Assistant Director of Non-acute Commissioning	NHS Havering	Panel Member
Designated Nurse Consultant	NHS Havering	Panel Member
Service Manager Safeguarding and Service Standards	L B Havering Children's Social Care and Learning	Panel Member
Head of Patient Experiences	London Ambulance Service	Panel Member
DI Child Abuse Investigation Team	Metropolitan Police service	Panel Member
Director of Nursing	Barking, Havering and Redbridge University Trust	Panel Member
Head Nurse Safeguarding	Barking, Havering and Redbridge University Trust	Panel Member
Additional Educational Needs Services Manager	Children Social Care and Learning	Panel Member
Commissioning Manager[3]	NHS Havering	Panel Member
Legal Services Manager	L B Havering	Legal Advisor

2.8 Kevin Harrington was appointed to draw up an integrated chronology of events during the period under review and to produce this Overview Report, with an accompanying Executive Summary and an Action Plan, integrated across services. Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has a particular interest in Serious Case Reviews, in respect of children and vulnerable adults, and has worked on more than 30 such reviews. Mr Harrington is also involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council. He has served as a magistrate in the criminal courts in East London for 15 years

2.9 The SCR Panel determined that agencies should provide detailed accounts and analysis of their contact with the family from May 2009, when Ms F became pregnant with Child D, until his death, and should provide summary accounts of any relevant contact outside that period.

[3] This officer was unwell and did not attend any Panel meetings, but was represented by a number of deputies.

3. SUMMARY OF EVENTS

3.1 Ms F received medical treatment between 2005 and 2007. She subsequently moved to Romford and, in April 2009, her pregnancy with Child D was confirmed. The GP with whom this was first discussed was a doctor in training, who did not pick up the issue of her previous contact with health services.

3.2 However, in June 2009 she again approached her GP, saying that she was concerned that she might again develop health problems, and wanted advice. Her GP referred her to a local NHS service, provided by the North East London Foundation Trust. An officer from that service telephoned her and she was given contact details for a local service. No further action was taken, other than to report back to the GP.

3.3 Ms F was generally compliant with ante-natal care arrangements and, at her first appointment, discussed her health problems. The midwives referred her to a Consultant Obstetrician with specialist responsibilities. However, the appointment with this obstetrician was delayed and the assessment eventually carried out was not sufficiently thorough. The obstetrician concluded that Ms F was able to ask for help if necessary and did not require consultant care. She did not refer Ms F to any other services.

3.4 Ms F was employed in a civilian capacity by the Metropolitan Police Service. She saw an occupational health adviser several times. The occupational health adviser tried, with Ms F's consent, to draw together information from her GPs and the hospital where she was due to have her baby, but the responses from those services were slow and incomplete.

3.5 When Child D was born he was healthy except that his weight was low. Mother and baby were both judged to be well and were discharged after a couple of days in hospital. Community midwives, who had not been made aware of her medical history, visited twice and had no concerns, before routinely transferring care to the Health Visitors.

3.6 A Health Visitor, who again had not been made aware of the history, visited promptly and recorded no concerns. The Health Visitor called again a week later and, on this occasion, Ms F spoke about some aspects of her medical condition. The Health Visitor called the midwife who had been visiting, who said that she had not felt any concerns about the family.

3.7 The Health Visitor returned the following week, finding Ms F's presentation and confidence much improved. However, Child D's weight gain was slow and the Health Visitor arranged for them to be seen by the GP the following day. The GP carried out a full assessment of the child but found that no action was necessary, except that he be kept under review.

3.8 When the Health Visitor called again, a week later, Ms F seemed well and the flat was tidier than when she had last visited. During March and April Child

D was seen several times at clinic and had two sets of immunisations. There was nothing in his presentation to give cause for concern.

3.9 At the beginning of May, just after midnight, emergency services were called to a domestic disturbance involving Ms F and Mr E. Ms F had called the London Ambulance Service, who attended and in turn called police. Police officers took Ms F to a local hotel to stay overnight. Mr E told police that he believed that his partner was unwell but that she was unwilling to admit this and seek support. Child D was described as well looked after, in a clean and secure environment, and there were no immediate concerns for his safety.

3.10 This attendance was routinely notified by police to Havering Children & Young People's Services (CYPS). This notification was reviewed by a manager who detailed an unqualified Family Support Worker to undertake a home visit. The Family Support Worker made an unannounced visit, accompanied by a student social worker.

3.11 Ms F told the two workers that she had been unwell previously and had been helped by specialist services. She denied any current ill health and said she had support from relatives. However she acknowledged feeling low and isolated, with no friends in the local area, and was home alone a great deal because Mr E worked six days each week.

3.12 The flat was found to be warm, clean and tidy with appropriate toys for Child D. Ms F agreed to a referral to a Children's Centre, which would offer general support and contact with other parents. She agreed to allow information to be shared with the Health Visitor and the Family Support Worker spoke to the Health Visitor the following day. This was the first time that the Health Visitor was made aware of Ms F's history of ill health.

3.13 The Family Support Worker subsequently spoke again, by telephone, with Ms F and with Mr E, who said that he remained concerned about Ms F. He also said that he was doubtful that Ms F would make use of services. The Family Support Worker suggested various voluntary services which might assist and indicated that the local authority CYPS would not be taking further action.

3.14 The following day the Health Visitor saw Ms F who told her she was feeling unwell and now disclosed her medical history. The Health Visitor advised that she would discuss the situation with the GP and subsequently arranged a GP appointment for Ms F. She also made a Children's Centre referral, but did not detail the nature of Ms F's medical history.

3.15 A CYPS manager reviewed the findings of the Family Support Worker and decided that the family situation did not meet the threshold for the completion of a formal assessment by CYPS but that the family should be referred to a Children's Centre for family support services. That referral had in fact already been initiated by the Family Support Worker (who recorded that the analysis of risk level was "low"). CYPS then formally terminated their involvement.

3.16 In June Child D had his third immunisations and his weight was noted to be improving. However, when Ms F saw her GP, who carried out a very full review, she was referred to a specialist service as the GP was very concerned by her presentation. In response to this referral the specialist service did not take any direct action but, instead, contacted the Health Visitor and asked her to refer Ms F to another service.

3.17 The Health Visitor did as she had been asked and made the referral, setting out the situation as it had been described by the GP in the initial referral, but without using the word “urgent”. She faxed this referral two days after the GP had made the original referral. The fax was recorded as received six days after it was sent, and reviewed five days after that. It was given a lower priority because it contained no indication of urgency. In due course Ms F received a letter inviting her to see a doctor from the specialist service towards the end of July.

3.18 Child D was seen at clinic routinely in the first week of July and satisfactory weight gain was noted. However, later that day Mr E called police. He had been contacted by a neighbour after Ms F had knocked on the neighbour’s door, asking for help. Emergency services attended the family home, arriving at around the same time as Mr E. Ambulance staff have documented that Child D was in cardiac arrest, showing no signs of life and was beyond resuscitation. He had been dead for several hours.

3.19 Ms F was arrested and taken to a police station, where she was judged to be unfit for interview. Subsequently she was bailed by the Metropolitan Police Service to reside at a hospital. A post -mortem was conducted the next day and found that:

- cause of death was unascertainable
- there was no evidence of injuries indicating abuse
- there was no evidence of disease, infection or illness found.

3.20 The Serious Case Review was initiated without delay and concluded in February 2011, within the government’s target timescale of six months.

3.21 Ms F was charged with and admitted one count of neglect, eventually receiving a sentence of 16 months in prison.

4. CONCLUSIONS: LEARNING POINTS AND MISSED OPPORTUNITIES

4.1 Before his death there had been no evidence that Child D was not being adequately cared for, and the Review found that there were never concerns which should have led to any child protection intervention.

4.2 However, there was a great deal of evidence that his mother was unwell, including repeated direct requests from her for help. There were weaknesses in the sharing of information but all the "treating" agencies had some knowledge of the problem, and the consequent risks to Child D, but failed to give adequate priority to the need to address her illness.

4.3 Specialist health services had a particular responsibility to address this concern but failed adequately to do so. Their response to the referral from primary health care services in June 2010 was disappointingly weak: no assessment was carried out in the community and there was avoidable delay in offering a specialist appointment, in response to a referral the GP had described as "urgent". There is no evidence that these services took account of there being a vulnerable child in the family.

4.4 Initially the GP failed to ensure that maternity services were aware of Ms F's full medical history. Maternity services picked this up anyway but there were delays and weaknesses in the assessments carried out by obstetricians. Then all the other health services involved failed to ensure that the Health Visitor was aware of the relevant history.

4.5 The Health Visitor only became aware of that history after the one occasion, in May 2010, when Ms F came to the attention of police. Nonetheless, although she was always prompt and sympathetic in her dealings with the family, the Health Visitor did not carry out comprehensive assessments.

4.6 Children and Young People's Services were only briefly involved, following up the incident involving police. They should not have deployed an unqualified officer to carry out an assessment of a child's safety. There was then avoidable delay in making child-focussed support services available to the family.

4.7 The Common Assessment Framework (CAF) was established as the appropriate process to follow where the "universal" agencies identify that a child might have "additional" needs - such as those which might arise from Ms F's situation. This was the appropriate inter-agency procedure to be followed to flag up and begin the analysis of the additional needs of Child D which arose from his mother's problems. The GPs, maternity services or Health Visitor might have made use of this "tool" but none of them did so.

4.8 Through her employment Ms F was in touch with impressive occupational health services. However, the contribution from those services was undermined by slow and inconsistent feedback from other health services.

4.9 Agencies have found a number of themes in this Review which were also identified in a previous Serious Case Review in Havering in 2009. It is consequently necessary to check that lessons learned from that Review have been thoroughly followed up.

4.10 The principal learning point relating to the process of this Review was that some agencies failed to submit reports which were concise, punctual and in the standard format which had been agreed. This meant that the process of analysing and cross-checking those reports was more complicated and time-consuming than necessary.

5. OUTCOME OF THE SERIOUS CASE REVIEW

5.1 This Review involved brought to light a number of issues about the ways in which agencies work, individually and together, to protect children. Those issues have led the Havering Safeguarding Children Board to draw up an Action Plan, which aims to ensure that the lessons learnt from this Review are taken fully into account in managing and delivering services to children and their families.

5.2 The principal issues tackled in that Action Plan are

- Giving appropriate weight to the needs of children when working with parents who are unwell.
- The availability and adequacy of specialist health services.
- The use of the Common Assessment Framework.
- Ensuring that assessments are carried out by appropriately qualified staff.