CHILD B

A SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

1. INTRODUCTION

1.1 Child B died in December 2008, aged six weeks. He was the only child of his parents, Ms C and Mr D. The Havering Local Safeguarding Children Board (LSCB) considered the circumstances of the death and initiated a Serious Case Review (SCR), in line with the requirements of the government's statutory guidance, Working Together to Safeguard Children 2006 . The Terms of Reference of that SCR are attached at Appendix A. This is the Executive Summary of the Overview Report from the SCR, which was completed in May 2009.

1.2 The agencies which contributed to the SCR are

- NHS Havering (Havering PCT)[1]
- Barking Havering & Redbridge University Hospitals Trust
- Metropolitan Police Service.
- London Probation Service.
- London Borough of Havering Social Care and Learning – Children and Young People's Services.
- London Ambulance Service NHS Trust

Child B's parents and grandfather also contributed to the SCR.

2. SUMMARY OF EVENTS

2.1 Ms C received full ante-natal care and Child B was a healthy baby, apart from a relatively common heart condition which was being monitored by the hospital where he was born. After discharge from hospital, the family received follow-up services from midwives, and were then visited once by a Health Visitor and three times by a Community Nursery Nurse.

2.2 On the day of Child B's death, the London Ambulance Service was called to the family home in the late morning. They found the baby dead and his mother distraught. They were concerned that the child had been in cardiac arrest for some time before emergency services were alerted.

2.3 When Child B died, he and his mother had been asleep together on a sofa. Mr D was working away from home. Ms C was isolated from family and friends. She had drunk some alcohol and there was evidence that someone in the house had been using illegal drugs. Ms C was subsequently arrested in connection with possible charges of neglect and drug use. A criminal investigation continues.

2.4 A post mortem did not identify any injury, congenital abnormality or natural disease process that might have caused or contributed to the death. The results of toxicology tests indicate that use of alcohol or drugs played no part

[1] In line with national policy, Havering PCT has established an Autonomous Provider Organisation (APO) to manage directly provided services, at arms length from the commissioning PCT. For the purposes of this SCR, all references are to the statutory public body, the PCT

in his death. The formal cause of death is expected to be recorded as Sudden Unexplained Death in Infancy (SUDI).

3. KEY THEMES AND LESSONS LEARNED

3.1 No agency had any information, or should have taken any action, which would have prevented the death of Child B

3.2 The family had no significant history of contact with the agencies contributing to the SCR. Ms C had been treated in primary care for depression on three occasions, most recently in 2007. She had been under particular pressure during her pregnancy, as her mother had become terminally ill, and died soon after Child B was born.

3.3 Ms C had mentioned her most recent episode of depression to the first midwife she saw, when booking her ante-natal care. This should have triggered a referral for specialist medical assessment but that was not discussed with Ms C. The issue of previous depression was not subsequently picked up by any of the staff who saw Ms C.

3.4 Ms C states that, for the last two months of her pregnancy, she was visibly anxious and distressed about her mother, but that ante-natal services did not respond to this. That account is not accepted by those services.

3.5 Her distress continued after her mother's death. The SCR found that the midwifery and health visiting services should have been more responsive to this, should have liaised more closely and both services should have talked to Ms C about referral to specialist mental health services The health visiting service should have given the case a higher priority and screening for post-natal depression should have been carried out.

3.6 It may have been appropriate to use the Common Assessment Framework, part of the policy initiative aimed at promoting more effective, earlier identification of additional support needs, particularly by universal services.

3.7 Although there were clearly issues of vulnerability, which might indicate early safeguarding concerns, the SCR did not find evidence of any immediate or inevitable damaging impact on the capacity of this family to parent Child B.

3.8 It has not been established that the death of Child B is directly related to "co-sleeping" with his mother – they had fallen asleep together on a sofa. Nonetheless, there is clear evidence from Child Death Review processes, and SCRs, of co-sleeping as a contributory factor in child deaths. Alcohol is a significantly aggravating factor.

3.9 The SCR Panel made suggestions for changes to the Review process, both locally and nationally, to improve efficiency and analysis of lessons learned from such exercises.

.4. RECOMMENDATIONS FROM THE OVERVIEW REPORT

4.1 Introduction

4.1.1 These recommendations are in line with the Government's guidance[2] that Serious Case Reviews should "focus on a small number of key areas with specific and achievable proposals for change". They arise directly from the contributions to this Serious Case Review.

4.1.2 Serious Case Reviews require comprehensive examination of agencies' processes and practice. The learning points arising from that examination may not relate directly to the events which have given rise to the Serious Case Review, but, where they may promote overall good practice, it is right that they should be reflected here

4.1.3 These recommendations are all important but none are so urgent as to require immediate attention. They can be dealt with in the normal course of service planning.

4.2 Recommendations to the Havering Local Safeguarding Children Board

4.2.1 The LSCB should implement arrangements for monitoring the extent and quality of use of the Common Assessment Framework

4.2.2 The LSCB should review the availability and effectiveness of early intervention support services in the light of the issues arising from this case.

4.2.3 The LSCB should discuss with the London Safeguarding Children Board the introduction across London of agency-specific standardised templates for reports (IMRs) to be used by individual agencies contributing to Serious Case Reviews

4.2.4 The LSCB should review the composition and membership of its Serious Case Review Working Group and Executive Monitoring Group in order to have a single group responsible for conducting reviews.

4.2.5 The LSCB should make representations to the Department for Children, Schools and Families about the processes for conducting Serious Case Reviews, which should ensure that there is a proper balance between the requirement for independence and the need for the most effective deployment of resources.

4.3 Recommendation to the Barking, Havering and Redbridge University Hospitals Trust and the Havering Primary Care Trust

4.3.1 The two Trusts should jointly review and strengthen as necessary the arrangements for liaison and joint working across the midwifery, health visiting

[2] "Working Together" (2006) Paragraph 8.34

and GP services, with particular reference to the issue of early concerns about vulnerability.

APPENDIX A

Child B London Borough of Havering Serious Case Review

Terms of Reference

An Extraordinary meeting of Havering's Local Safeguarding Children Board was convened on 9th January 2009 to give consideration to whether a Serious Case Review should be initiated in regard to Child B.

The LSCB decided on 9 January 2009 that the criteria for initiating a Serious Case Review as set out in paragraph 8.5 of Working Together were met and a Serious Case Review would be initiated. Terms of reference were agreed. At the Serious Case Review panel meeting of 3 April 2009, panel members agreed that that Independent Chair of the panel should re-draft the terms of reference in order to provide greater clarity and distinction between review processes and questions to answer in reviewing case interventions themselves.

The Panel agreed that the Independent Chair of the panel should then seek agreement from the Chair of the Havering Safeguarding Children Board for the re-ordered terms of reference. This agreement was provided by the LSCB Chair on 8th April 2009.

The Terms of reference were agreed as below.

PROCESS

Timescale

1. The Serious Case Review process as a whole needs to conclude by 12 May 2009. On this day at the latest, the LSCB staff members need to send to OFSTED the overview report, the executive summary, the integrated chronology and all individual management reports (IMRs) and chronologies along with minutes of panel meetings and associated documentation.
2. All IMRs and chronologies to be completed by 20 March 2009.

Review Processes

3. All agencies involved in the SCR will complete:

- An Internal Management Review.
- A separate chronology of their involvement with Baby B's family.

All agencies should complete the above in line with the requirements of Working Together to Safeguard Children 2006, the London Child Protection Procedures Edition 3 – 2007 and Ofsted's grade descriptors. The guidance set out on pages 174-177 should be followed closely to ensure all the requirements are contained within the Individual Management Review. Particular reference is made to critical analysis of the agencies involvement being included in the individual Management Report.

4. The Serious Case Review will take into account lessons that can be learnt from national and local research and practice issues and the most effective way of implementing the lessons to be learned.

5. An Executive Monitoring Group should be set up to enable additional senior officer review within LSCB agencies. This group will be advisory in nature insofar as the contents of the review are concerned.

   The Executive Monitoring Group will involve the Executive Lead for each agency involved and take responsibility for:

   - Reviewing the progress and quality of the Serious Case Review.
   - Developing a media and communication strategy.
   - Ensuring appropriate legal or other advice is available to the Serious Case Review.
   - Ensuring that parallel investigations and communication with the Coroner/ Crown Prosecution Service are effectively progressed.

6. **Organisations to Compile IMRs**

   - NHS Havering
   - Barking Havering & Redbridge University Hospital Trust
   - Metropolitan Police Service
   - London Probation Service
   - North East London Foundation Trust
   - Havering Council Children's Social Care and Learning Department.

Independent Input

7. Those conducting management reviews of individual services will have had no direct involvement with the child or family, or the immediate line management of the practitioner(s) involved.

8 An Independent Person/Organisation should be appointed to:

   - Co-ordinate the submission of Individual Management Reviews.
   - Co-ordinate the submission of individual agency chronologies.
   - Complete an Integrated Chronology.
   - Produce the LSCB Overview Report and present it to the LSCB.

- Produce the Executive Summary.
- Produce the Integrated Action Plan.
- Attend the LSCB and Executive Monitoring Group to report progress on the Serious Case Review and ensure that any issues arising from the Serious Case Review are reported.

.9. A separate Independent Person/Organisation should be appointed to:

- Chair the Serious Case Review Panel.
- Report to the LSCB and Executive Monitoring Group about the progress of the Serious Case Review and any key issues, including delays are effectively communicated.
- Ensure the requirements of the Ofsted grade descriptors for Serious Case Review's are met.

10. The LSCB will give consideration to involving a General Practitioner representative on the Serious Case Review panel in an advisory capacity because Baby B's mother's mental health issues were managed at General Practitioner level.

Family Involvement

11. Family members will be informed about and invited to contribute to the Serious Case Review. The independent author of the LSCB Overview Report will take the lead role in progressing the facilitation of family involvement.

SCOPE OF REVIEW

1. The Serious Case Review should review the period from 1st January 1990 to 17th December 2008, so that issues relating to mother's mental health and father's involvement with the Police in matters relating to use and supply of drugs and dishonesty could be covered by the review.

2. The family history/background information will include any known history of the parents with Health Care Services, Social Care & Learning, The Police Service, Drug Agencies, Mental Health Services and Probation Services.

SPECIFIC REVIEW QUESTIONS TO CONSIDER

The review and all IMRs will need to consider the issues as outlined in Working Together to Safeguard Children (2006). The review and IMRs will also need to pay attention to the following specific issues which appear to be relevant to the LSCB in Havering.

1. How effectively the universal health services involved with the family worked together to meet the needs of Baby B and support the family. In particular the Serious Case Review should consider whether the universal health services:

    - Identified parental vulnerability and its impact on parenting capacity

    - Identified historical factors such as mental health, domestic violence, drug and alcohol use including the use of prescribed medication, which may have impacted on parenting capacity

    - Analysed current and historical factors, assessed risk, provided a co-ordinated response and made appropriate referrals

    - Shared accurate information, communicated it in a timely manner and provided a co-ordinated response to ensure Baby B's needs were met and his welfare safeguarded.

    - Had appropriate knowledge/skills to identify the signs and symptoms of child protection and follow child protection procedures.

    - Failed to identify child protection concerns

2. How significant if at all was the time taken to obtain toxicology results in relation to the substance found in the household on 17 December 2008 bearing in mind that in other situations, there might be a need to know more urgently to add to the ability to protect other children.

3. Are there implications for ways of working; single and inter-agency training; management and supervision; working in partnership with other organisations, that need to be progressed by the LSCB partner agencies?

4. Is there good practice to highlight, as well as ways in which practice can be improved?