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CHILD D

SERIOUS CASE REVIEW: EXECUTIVE SUMMARY

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On behalf of the Havering Area Child Protection Committee

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1. Introduction

1.1 Child D, born 27th March 1992, died on 20th August 2001, as a result of poisoning with salt. His mother was charged initially with his murder; the charge was subsequently changed to manslaughter.

1.2 As Child D and his family lived in the London Borough of Havering, the Havering Area Child Protection Committee decided that a Serious Case Review should be undertaken. This is in line with the government's guidance contained in" Working Together to Safeguard Children".

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

- a description of the Serious Case Review process
- a narrative summary of the key events
- a summary of the lessons to be learned from the Review
- the recommendations made at the conclusion of the Review

1.4 The Action Plan arising from the Review is attached.

2. Serious Case Review Process

2.1 A number of statutory agencies were involved with Child D and his family when he died. A "Stakeholders' Group" was formed, consisting of senior representatives of those agencies. That group, chaired by the Executive Director of Social Services, London Borough of Havering, managed the process of the Serious Case Review.

2.2 Internal Management Reviews were carried out by:

- London Borough of Havering Social Services Department (completed 19th December 2001)
- London Borough of Havering Lifelong Learning Department (completed 27th September 2001)
- Barking and Dagenham Primary Care Trust (completed 14th December 2001)
- Barking, Havering and Redbridge Hospitals NHS Trust (completed 14th December 2001)
- Great Ormond Street Hospital for Children NHS Trust (completed 25th September 2002)
- London Borough of Camden Social Services Department (completed 30th November 2001)
- The Metropolitan Police (completed 17th October 2001)

2.3 Consultants were then commissioned to write an Overview Report. They were unfortunately unable to complete that task, and Kevin Harrington Associates Ltd were asked to do so in April 2004.

2.4 The Overview Report was therefore based on Internal Reviews and Action Plans which had been written and in place for some time. Some further exploration and clarification of issues was necessary in the process of writing the report. However, this was kept to a minimum, as the report was long outstanding. No further investigative action was taken and no interviews were carried out, so that none of those referred to in the report had an opportunity to comment on it, or on this Executive Summary.

2.5 The initiation of the Serious Case Review preceded the introduction of the London Child Protection Procedures. Individual agency reviews and chronologies had been written and compiled in a more diverse way than is now recommended. The Overview Report does not therefore strictly follow the London Procedures but takes account of them.

2.6 Between June 2004 and September 2004 drafts of this report were discussed and broadly agreed at Area Child Protection Committees, or Serious Case Review Sub-Committees, in Havering, Camden and Barking and Dagenham. It was agreed that the Overview Report be finally signed off after criminal proceedings were completed

2.7 Serious Case Reviews are principally concerned with how agencies work, separately and together, to protect children. They do not address issues of innocence or guilt in relation to any criminal actions which may have taken place. The Overview Report does reflect the concerns expressed in Individual Agency Reviews about the circumstances leading to the charges faced by Child D's mother, but makes no further assumptions.

2.8 Child D's family was not involved in the process of the Serious Case Review. The completion of the Serious Case Review then coincided with the criminal trial of his mother. It was therefore agreed by the Stakeholders' Group that any direct contact with the family about this process should also await the conclusion of the criminal proceedings.

2.9 The issue of fabricated or induced illness is central to the Review. It is referred to throughout the report as FII. The term "Munchausen's Syndrome by Proxy" is no longer in general use: it fails adequately to recognise the criminal nature of what is described.

3. Summary of Events

3.1 Child D lived with his family in Havering. Before February 2001, when he was approaching his ninth birthday, he was not known to any of the agencies involved

in this review, apart from his school and his GP. He was a healthy boy, said to enjoy karate and swimming.

3.2 The family are white British. There is no indication that any cultural, linguistic or religious factors impacted significantly on the management of this case.

3.3 In February 2001 Child D was seen at the Accident & Emergency Department of Oldchurch Hospital in Romford with abdominal pain. He was admitted to Oldchurch on 1st March 2001. His appendix was removed but his recovery was poor. There were a number of occasions when blood was found in his urine. No diagnosis could be made and he was transferred to Great Ormond St Hospital (GOS) for specialist advice and treatment.

3.4 Child D spent 2 weeks in GOS. There were further instances of blood in his urine for which no definitive organic explanation could be found, though it was concluded on discharge that the cause was infection. The possibility that his urine was being contaminated externally was raised. On 2 occasions his intravenous line was found to contain white powdery substance. His bandages were interfered with.

3.5 FII was explicitly considered and overt 24 hour surveillance was initiated. There were no further instances of haematuria or line tampering and he was returned to Oldchurch, without a clear diagnosis.

3.6 Child D remained in Oldchurch for 12 days without surveillance. Haematuria re-presented on a number of occasions. During this time Child D was seen individually by a psychiatric nurse whose report indicated that Child D was seriously psychologically and emotionally damaged.

3.7 On 4th April 2001 Child D's father made comments that raised concerns for the possibility of fabricated or induced illness.

3.8 This led to the first formal child protection referral to Havering Social Services. A plan was agreed, consisting of investigation by the Social Services Department and monitoring at Oldchurch. However, the Social Services Department did not follow up the agreed actions. Also Child D was discharged home by Oldchurch despite a multi-agency decision not to do so. Police took no investigative action.

3.9 Child D spent the next 2 months at home. During this time action on the case by the Social Services Department was allowed to lapse. He remained unwell and was seen at home by physiotherapists and the Hospital Teacher. They were concerned about Child D and found evidence of disharmony in the family home.

3.10 Child D's health deteriorated further and he was re-admitted to Oldchurch in June. There were a number of instances where he was said to have vomited,

and samples of vomit were presented by his mother, but vomiting was not heard or witnessed. His health did not improve and he was re-referred to GOS.

3.11 Child D was seen as an out-patient at GOS on 20th July and an organic diagnosis for his ill health was suggested. The diagnosis was a condition known as PANDAS, paediatric autoimmune neuropsychiatric disorder associated with streptococcal infection. Treatment proceeded on this basis and he was discharged home.

3.12 However, his health again deteriorated further. He was re-admitted to Oldchurch and transferred to GOS. In GOS, at the beginning of August, his blood gases were very abnormal, showing a progressive change from acute alkalosis (excess of salt) to chronic alkalosis.

3.13 On 5th August Child D's IV line was again found to have been interfered with, and to contain crystals. A Consultant Neurologist became very concerned at the possibility of FII and a Child Protection referral was made to Havering Social Services.

3.14 A Strategy Meeting was convened the next day. Arrangements for constant supervision by 2 people were introduced, and further enquiries were to be made by Social Services and hospital staff.

3.15 The meeting was reconvened on 9th August. There had been practical difficulties in maintaining 2:1 supervision and it was said that concern for Child D had diminished medically. Child D's parents were resentful of the level of supervision and Child D himself remained extremely unwell. PANDAS remained the working diagnosis for his illness and treatment was proceeding accordingly. It was decided that supervision should continue on a 1:1 basis and that the concerns about FII not be raised directly with Child D's parents. Further expert advice was to be sought, and the Strategy Meeting would re-convene on 16th August.

3.16 In fact the Strategy Meeting was deferred until 20th August, but from 16th August Child D's health deteriorated sharply. Sodium levels were noted to be elevated and initially it was felt that this was a result of dehydration secondary to diarrhoea. By 18th August he had become so unwell that he was transferred to Intensive Care.

3.17 The sodium levels in his blood were now so high that it was judged this could only be caused by salt intoxication. Feeds and empty bottles were examined and found to smell and taste strongly of salt. The matter was referred to Police who attended GOS and seized salt, milk and feed apparatus.

3.18 Child D's health failed to improve and he developed brain swelling, a side effect of salt intoxication. He was pronounced dead on 20th August 2001.

4. Lessons to be Learned from the Serious Case Review: Fabricated or Induced Illness

4.1 Fabricated or Induced Illness: Identification

4.1.1 The first explicit reference to the possibility of induced illness was on March 19th 2001. Between then and Child D's death there was substantial evidence to support the possibility of FII. That evidence included

- medical symptomatology indicative of poisoning
- forensic evidence of interference with equipment
- repeated witness evidence suggestive of tampering
- a correlation between surveillance and cessation of symptoms

4.1.2 The possibility that FII was a cause of Child D's ill health was explicitly considered at a number of formal meetings in the community and at both hospitals. It was clearly also discussed informally within the networks of those caring for Child D.

4.1.3 However, FII was never explicitly identified as the cause of Child D's illness and never became the primary issue to be tackled in the management of his situation.

4.1.4 There was an over-concentration on finding an organic diagnosis. The diagnosis of PANDAS is not unanimously supported but, more importantly, it had the effect of mitigating the concerns for FII. The possibility that FII or poisoning might be happening as well as PANDAS does not seem to have been explicitly considered. Medical staff stated that "we have excluded other potential causes" (other than PANDAS) but this did not fit with the weight of evidence supporting FII, which was never refuted.

4.2 Fabricated and Induced Illness: Working with Parents

4.2.1 It is always difficult to raise concerns about possible child abuse directly with parents. There are particularly problematic issues in respect of FII, where there have been instances of harm increasing, changing or accelerating when parents are confronted. Guidance stresses the need not to further jeopardise a child's safety by confronting carers without clearly thinking through the issues and possible consequences.

4.2.2 Nonetheless, the Review found an unnecessary and confusing degree of avoidance in this case. There is no point at which the parents were unambiguously told what was suspected.

4.2.3 They can hardly have been unaware of the nature of the concerns. Also, as the Department of Health Guidance indicates, "Family members have a right to

know what is being said about them". That right is of course not absolute but does not seem to have been given adequate weight.

4.2.4 To a degree, the failure to raise the issue reflects a sense of the agencies not being sure how to deal with the case. There were also clearly occasions when this was avoided in the face of parental challenge. There was no police investigation which would necessarily have brought the issue into the open.

4.2.5 Confronting this issue would not have been easy but concerns were concrete and identifiable; there was a succession of incidents and sources of evidence of possible FII. The possibility of FII should have been discussed with the parents, in the context of a planned child protection and criminal investigation.

4.2.6 The guidance available to those dealing with FII stresses the need for caution in telling parents that there are concerns of this nature. However, there is little practical guidance on how professionals should proceed once it is decided that this step is necessary.

4.3 Fabricated or Induced Illness: Surveillance

4.3.1 Child D and his parents were under overt surveillance at Oldchurch and at GOS. The second episode at GOS briefly included 2:1 surveillance. Police asked GOS for permission to set up covert video surveillance but this was refused.

4.3.2 The surveillance arrangements were well intended. Indeed, they may be seen as effective during the first admission to GOS, in that once they were instituted there were no further instances of suspicious haematuria or vomiting. Havering SSD committed extra resources to the 2:1 surveillance arrangements at GOS, in an attempt to ensure that they were as sound as possible. However, there was a return to 1:1 supervision as these ambitious arrangements were not sustainable. They could have been better thought through and organised.

4.3.3 Surveillance has elements of observation, protection and evidence-gathering. These constituent parts need to be specifically identified and owned by partner agencies. The following issues emerged:

a) The aims of surveillance need to be clear and explicit, and to distinguish between observation, the gathering of evidence and immediate protection.
b) Surveillance cannot be combined successfully with one to one nursing, and indeed there is some inevitable conflict between the two roles.
c) One to one nursing supervision cannot prevent all severe episodes of induced illness.
d) Responsibility for monitoring both children and their parents must be specified.
e) Effective surveillance requires a forensic approach from staff with appropriate training.

f) There are practical difficulties in maintaining effective surveillance which includes feeds and communal areas as well as at a bedside.
g) Surveillance must be supported by good, consistent record-keeping
h) There are significant management, organisational and funding implications in the decision to introduce external staff for the purpose of surveillance.
i) A continuing surveillance operation may adversely affect the morale and performance of staff and the ability to maintain normal levels of service.

4.3.4 Covert video surveillance (CVS) was not put in place. There were practical difficulties but there was also a lack of clarity about how, when and why such arrangements may be made. Concerns were expressed about possible legal action by parents claiming that there had been a breach of the requirements of the Human Rights Act 1998. The roles and responsibilities of agencies may not have been sufficiently clearly set out.

4.4 Fabricated or Induced Illness: a Forensic Approach

4.4.1 Practical arrangements must reflect the recognition of possible FII: feeds must be "tamper-proof", fridges must be lockable. This did not happen at GOS towards the end of Child D's life.

4.4.2 Secondly, teams must take account of, and be equipped to deal with, evidential issues. The Police need to give a clear lead here, viewing the ward and surrounding areas to give crime prevention advice.

4.4.3 There is an area of overlapping responsibility between toxicology services and the Forensic Science Service. An earlier and greater involvement of the Forensic Science Services may have made a difference to the identification of evidence and the management of the case.

4.5 Fabricated or Induced Illness: General

4.5.1 Issues emerged in the Review around professional hierarchy. Nursing staff at Oldchurch felt that their concerns were being dismissed by medical staff and there is evidence to support that view. This is linked to the experience of the professionals in Havering who regarded themselves as outside the "core team" – the physiotherapists, dieticians, play specialists and Hospital Teacher. They were concerned, but did not feel able to raise those concerns as child protection referrals. Management and supervision arrangements were not sufficiently robust to identify and deal with this.

4.5.2 FII differs from other manifestations of child abuse in its location. The extent to which FII occurs in hospitals, rather than in the family home, is significant. There is a common assumption that being in hospital is in itself a protective measure. This may be correct but the management of FII requires a

more critical examination of the action that is necessary to ensure that a child is adequately protected.

4.5.3 The case raised issues about cover arrangements outside office hours. There is a greater possibility that this will be an issue in cases involving FII and hospital admission. This should be explicitly addressed in case planning.

5. Lessons to be Learned from the Serious Case Review: General

5.1 Assessment

5.1.1 No comprehensive assessment of Child D's circumstances was ever carried out. The Review found evidence of poor practice and management weaknesses in the Havering Social Services Department. At that time, the Department had been criticised in a number of external inspections.

5.1.2 The Metropolitan Police did not carry out a criminal investigation into the possibility that FII was taking place. The Review found that this would have added to the overall understanding of the situation, and may have prevented abuse.

5.1.3 Psychiatric services were not adequately involved in the case, despite the opportunities that were available at both GOS and Oldchurch, as well as in the community.

5.1.4 Child D was never seen by a social worker or police officer. Although there was evidence that those staff involved in his day to day care worked conscientiously with him, there was insufficient focus on the child in the discussions and investigations into FII.

5.2 Communications and Information Sharing

5.2.1 Agencies tried hard to work co-operatively in difficult circumstances. The number of communications issues identified reflects the complexity of the situation, rather than a seriously disjointed approach.

5.2.2 The most significant general communications issues are detailed below.

a) When Child D was being referred between Oldchurch and GOS, the concerns about FII were either omitted or inadequately specified by both hospitals.
b) Liaison between professionals following the first child protection referral was not adequate.
c) Havering SSD were not adequately represented at the Professionals' Meeting of 14th June

d) The discharge letter from GOS, relating to the admission between 14th March 2001 and 28th March 2001 was not written until 16th July 2001.
e) The Emergency Duty Team in Havering was not briefed by day staff
f) The GP was not at any of the meetings about Child D and the important information he held was not made available to other involved professionals
g) There was inconsistency in attendance at the various meetings and no explicit arrangements for briefing those who did not attend.
h) Arrangements for internal communications and medical case conferencing within GOS could have been better, given the many different specialisms involved in Child D's care
i) There were problems in the hospitals as a result of various professional disciplines having different record-keeping arrangements – doctors writing in the medical notes, nurses the nursing kardex and various arrangements for other professionals. This caused difficulty in formulating and sustaining comprehensive planning

5.3 Use of Child Protection Procedures

5.3.1 Child protection arrangements and procedures were not always followed consistently. The initial child protection referral in April was not followed up as agreed. A decision was made to discharge Child D from Oldchurch Hospital in direct contravention of a Strategy Meeting decision. Subsequent child protection Strategy Meetings failed to give adequate priority to protective measures and no full Child Protection Case Conference was convened at any point.

5.4 Supervision and Consultation

5.4.1 Cases of FII are complex and difficult to understand. They are relatively unusual and more recently have been the subject of adverse media coverage, aimed particularly at paediatricians. Such cases are very challenging for staff of all professional disciplines. Arrangements for supervision, guidance and support to staff in some agencies were not sufficiently sound.

5.5 Record Keeping

5.5.1 Most agencies identified areas in which their record keeping could have been better, and, in some instances there was evidence of poor record-keeping. Sound record-keeping can assume a particular significance in cases of FII. The Guidance issued by the Royal College of Paediatricians sets out how the maintenance of planned and detailed observations and records can contribute to analysis and identification of FII.

5.6 Training

5.6.1 In dealing with Child D and his family, some professionals did not have an adequate grasp of the nature and complexity of FII. Some key staff in all agencies working with children need to have expert knowledge and to have leadership in these cases, and a process to disseminate adequate knowledge should be in place.

5.6.2 At the same time cases of FII are rare and this case, in both its presentation and outcome, was particularly unusual. All agencies have responded to the staff training needs identified from the Review

6. Conclusion

6.1 It is often the case in enquiries and Reviews that over time a number of incidents are observed but misinterpreted or given insufficient weight. Only when viewed collectively is their significance recognised. The Overview Report found something more than that; an added dimension of denial and reluctance to accept the implications of the evidence of FII.

6.2 It was not the case that FII was overlooked as a possibility until convincing evidence emerged. On the contrary, it was repeatedly and explicitly recognised as something for which there was legitimate concern. Somehow that concern was then not given the priority it demanded.

6.3 This is not to say that those dealing with Child D and his family should have anticipated his continuing deterioration and death. Rather, as the Police Management Review concludes:
"A timely and robust investigation by the statutory agencies into the initial causes for concern may have altered subsequent events and saved his life".

7. RECOMMENDATIONS

7.1 Introduction

7.1.1 This section of the Review details general recommendations, not those contained within individual agency Management Reviews. As detailed in the introduction to the Integrated Action Plan, many changes have already been made by agencies to their working practices as a result of the lessons learned from this case

7.1.2 In line with guidance in Working Together to Safeguard Children, this Review aims to

- minimise the number of recommendations
- make recommendations which can realistically be implemented
- ensure that recommendations are clearly linked to Review findings

7.2 Recommendations to all Agencies

7.2.1 Agencies should ensure that they maintain a "child-focussed" approach in cases of suspected FII and should recognise how easily that focus can be lost.

7.2.2 Although expert paediatric input is crucial to successful management of cases of suspected FII, there may also be too ready an acceptance of medical opinion. All agencies should recognise the fundamental importance of holistic assessment, led by the SSD and appropriately including all family members.

7.2.3 All agencies should ensure that they have systems for tracking the progress of decisions made in formal Child Protection meetings.

7.2.4 Agencies should ensure that their arrangements for the management of cases where FII is suspected are clear and explicit. Those arrangements should take account of the guidance issued by the Department of Health and the Royal College of Paediatricians. They should include consideration of the following issues:

- the need adequately to involve the Police, recognising the sensitivities that are likely to present
- the use of police expertise in deciding on a forensic approach
- specification of the role of psychiatric services in assessing cases where FII is suspected

7.2.5 There can be an over-reliance on the protection that is offered simply by being in hospital. In cases of FII, agencies should specifically consider this, and the possibility that harmful behaviour may be escalated, in agreeing child protection plans.

7.2.6 Cases of suspected FII are demanding. Agencies should ensure that supervision and support arrangements are robust, flexible and accessible, recognising the position of those professionals outside the core team.

7.2.7 Agencies should satisfy themselves that their record keeping procedures are adequate in the light of the lessons from this case.

7.2.8 Cases involving suspected FII and admission to hospital are likely to require “out of hours” action: all agencies should be mindful of that in determining arrangements for assessment, identification and case management.

7.2.9 Cases of suspected FII are likely to involve a large number of professionals. In hospitals, a number of Consultants may be involved. This may make overall control and case management more difficult. Agencies should ensure that this is explicitly addressed in child protection planning

7.2.10 Area Child Protection Committees should ensure that General Practitioners are adequately involved in the management of child protection cases.

7.3 Recommendations to the Department of Health and the Department for Education and Skills

7.3.1 The Departments should issue detailed guidance on how professionals can work with parents suspected of involvement in FII

7.3.2 The Departments should work with the Police service to develop inter-agency guidance on the use of overt and covert surveillance in cases of FII

7.4 Recommendation to the London Child Protection Committee

7.4.1 The Committee should consider re-drafting Section 9.1 of the London Child Protection Procedures (which deals with FII) to take account of issues arising from this Serious Case Review

Serious Case Review: Child D

Integrated Action Plan

1. Introduction

1.1 The following agencies carried out management reviews of their involvement in the arrangements to protect Child D:

- London Borough of Havering, Social Services Department
- London Borough of Havering, Lifelong Learning Department
- London Borough of Camden, Social Services Department
- The Metropolitan Police
- Great Ormond Street Hospital NHS Trust
- Integrated Child Health Services, a partnership between Barking and Dagenham Primary Care Trust and the Barking, Havering and Redbridge Hospitals NHS Trust: this review also covered the roles of the Havering Primary Care Trust and the North East London Mental Health Trust

1.2 All the agencies have developed detailed action plans in consequence of their reviews. The NHS agencies in north-east London, which are configured in a different way than was the case in 2001, are working to one action plan.

1.3 Agencies have not waited for the conclusion of this process to change working practices. In the time that has passed since Child D's death, many of the objectives and targets set by the agencies in their action plans have been met and are subject to continuing monitoring. Changes have been implemented in the areas of referral process, record-keeping and sharing, assessment, including forensic requirements, and communications. All agencies have significantly enhanced their training and staff support arrangements in relation to cases of FII.

1.4 The passage of time has also seen the requirement on all agencies to review practice and make changes following Lord Laming's report on the death of Victoria Climbie, and issues highlighted in this report were also picked up in that process.

1.5 Consequently, this action plan is restricted to the identification of those strategic or inter-agency issues which should be formally considered by the three Area Child Protection Committees involved in this case. Again, many of the issues have already been dealt with within and across agencies. However, all participating agencies must now ensure that their action plans adequately deal with the issues detailed below and that they have arrangements in place to monitor local action plans to ensure that changes to working practices and arrangements are effective and sustained.

Integrated Action Plan

Issue	Action	Timescale	Lead
Ensuring that the lessons from this case are disseminated to all appropriate staff and performance is monitored	Briefing note to be cascaded to all appropriate staff, including GP's Key Performance Indicators to be set and reported by each agency to ACPC	2 months following ACPC approval of SCR Report	ACPC Chairs in Havering, Camden, Barking & Dagenham Lead officer, Child Protection, all agencies
Providing guidance for staff working with FII which covers 1) maintaining a child-focussed approach, including advocacy and working with those known to have a good relationship with the child 2) challenging medical opinion 3) assessing risk to children who are in hospital, including forensic requirements 4) "out of hours" arrangements	Supplement existing procedures with specific FII practice guidance and check-list	December 2004	Lead officer, Child Protection, all agencies
Training	Include FII in training programmes Inter-agency training to be provided	Continuing	Training Manager, all agencies
Supervision and decision-making	FII cases should always require input from a senior	To be confirmed when ACPC agrees SCR	Lead officer attending Stakeholder

	officer, above first line-management	report	Group, all agencies
Tracking and checking work carried out by other agencies	Tracking system to be established in all agencies covering child protection and child in need case planning	3 months following ACPC approval of SCR report	Lead officer, assessment, all agencies
Police involvement in suspected FII	Agencies to agree that all FII cases should be jointly investigated Procedures to be amended	To be agreed when ACPC approves SCR report	ACPC Chairs Lead officers, Child Protection
The role of psychiatric services	Assessment of FII cases must include psychiatric opinion Procedures to be amended	To be agreed when ACPC approves SCR report	ACPC Chairs Lead officers, Child Protection
Co-ordination of input to FII cases	FII Planning meetings, including "child in need" planning, to identify named core group of professionals with designated Chair Procedures to be amended	To be agreed when ACPC approves SCR report	ACPC Chairs Lead officers, Child Protection, all agencies
Record-keeping	Review record - keeping arrangements in the light of this case, including the development of shared records where possible	3 months from ACPC approval of SCR report	Lead officer attending stakeholder group for each agency
Detailed practice guidance on 1) surveillance 2) working with	DfES and DH to be requested to include in work programmes	When ACPC approves SCR report	Chair, Havering ACPC, on behalf of all agencies

parents			
London Child Protection Procedures	London Child Protection Committee to be asked to re-draft guidance on FII	When ACPC approves SCR report	Chair, Havering ACPC, on behalf of all agencies