CHILD N

A SERIOUS CASE REVIEW

LONDON BOROUGH OF HAVERING SAFEGUARDING CHILDREN BOARD

EXECUTIVE SUMMARY

11th October 2007

1. Introduction

1.1 Child N was born on 1st February 2006 and died on Christmas Eve of the same year. On 24th January 2007 criminal charges were preferred against both his parents in connection with his death. On 11th October 2007 both parents admitted causing or allowing the death of a child, contrary to section 5 of the Domestic Violence, Crime and Victims Act 2004.

1.2 This was a complex and demanding case, where concerns arose from the first month of Child N's life in relation to a number of issues, including substance misuse and domestic violence. Child N's name was included on the Child Protection Register under the category of physical abuse when he was 4 months old. He failed to thrive and his weight was being monitored. A number of agencies were involved in seeking to ensure his safety.

1.3 The Serious Case Review found that Child N's parents set out to deceive those agencies and succeeded in doing so. They did not do this by adopting a confrontational approach, although there were elements of intimidation. Instead they developed a pattern of minimal and intermittent engagement, which confounded the interventions of the agencies.

1.4 There was a consistently high level of concern for the safety and well-being of N, and agencies were seeking to address those concerns up to the time of his death. Staff in all agencies worked hard to discharge their responsibilities to N. Consistent legal advice was provided throughout the conduct of the case and, based upon information known at the time, the Review accepted that there was not sufficiently strong evidence to support an application to remove N from the care of his parents.

2. Background to Serious Case Review

2.1 The decision to conduct a Serious Case review was taken without delay.

2.2 The agencies contributing to this Review were

- Barking, Havering and Redbridge Hospitals NHS Trust (BHRT)
- Havering NHS Primary Care Trust (HPCT)
- London Borough of Havering (LBH) Children's Services (CS)
- LBH Drug and Alcohol Action Team (DAAT)
- LBH Housing & Environmental Health Services
- LBH Legal Services Department
- Metropolitan Police
- North East London Mental Health Trust (NELMHT)

2.3 Each of these agencies has reviewed and reported on its involvement. An independent consultancy company with specialist expertise has produced the Overview Report and this Executive Summary.

2.4 Child N's parents still face criminal charges and have not been involved in the Serious Case Review process. Extended family members were offered an opportunity to contribute to the Review but have not done so.

3. Summary Of Events Detailed In The Overview Report

3.1 The relationship between N's parents, Ms D and Mr C, commenced in 2004. Both were users of crack cocaine. Ms D denied use of drugs during her pregnancy but toxicology tests established that N was born with traces of cocaine in his urine. However, hospital staff did not share this information with any other agency until October 2006.

3.2 The family came to the attention of police on 27th February 2006 because of domestic disturbance when N was 4 weeks old, and to Children's Services in April 2006 following allegations that N had facial bruising. In May 2006 the family were living in homeless persons' accommodation and the first of a number of complaints from neighbours was made, to a Health Visitor, alleging noise, disturbance and drug use in their home.

3.3 In June 2006 a Health Visitor noticed marks to N's chest which were investigated by police and Children's Services. This led to the inclusion of N's name on the Child Protection Register. A Child Protection Plan was agreed, involving N's parents and extended family members. There were a number of subsequent incidents which reinforced fears that N was being physically abused. Although the family repeatedly avoided registration with a GP, all these incidents were subject to medical investigation. Injuries were found to be consistent with the explanation given by parents. Following one of these incidents, extended family members decided to play no further part in the child protection arrangements.

3.4 In September 2006 N lost weight and was admitted to hospital for a week. Hospital staff noted concerns about his parents' standards of routine care. He was discharged with arrangements for frequent monitoring of his weight. There were no further reported incidents of injury but concerns about his failure to thrive persisted. There were continuing allegations of drug use and reports of domestic disturbance, which were investigated.

3.5 N was found to be well and sociable when seen by a Health Visitor on 19th December 2006. It is now known that there was a serious disturbance at the home on 22nd December 2006, which was not reported to police. N was taken to hospital by ambulance on the morning of Christmas Eve but pronounced dead. An initial post-mortem indicated that he had died as a result of abdominal bleeding probably caused by a punch or kick. The pathologist gave his opinion that "this child has died from intra-abdominal haemorrhage due to a torn mesentery." He was also found to have a number of rib fractures of different ages.

4. Key Themes and Lessons Learned

4.1 N's parents deliberately resisted engagement with services. This avoidance should have been more resolutely and consistently challenged. The interventions of agencies should have been escalated as the lack of

engagement continued, and in response to attempts to delay medical investigations.

4.2 The Child Protection Plan addressed all the areas of concern but could have been more specific in what was required of the parents and the consequences of their not complying with those requirements. When extended family members ceased to participate in the arrangements to protect N, the Child Protection Plan should have been formally reviewed.

4.3 The issue of parental substance misuse and its implications for N's safety was not given sufficient weight, especially in the early stages of planning the management of the case. In part, this was because the evidence of substance misuse in pregnancy was not shared. This would have made it clear that N's mother was being untruthful. There was also insufficient specialist knowledge of substance misuse in children's health and social care services.

4.4 There were a number of instances where the potential significance of issues was not recognised by staff working in services not routinely involved in child protection work, such as housing officers, substance misuse workers and radiographers. As a result the overall quality of information available to the child protection network in the case was impaired.

4.5 The response to reports from neighbours could have been better co-ordinated. It concentrated on issues of anti social behaviour when there should have been a greater focus on child protection.

4.6 On two occasions requests for skeletal survey of N were refused by paediatricians because of the risk to such a young child of harm from radiation. A further opportunity was missed when N was in hospital in September 2006. We now know that skeletal survey would have revealed signs of non-accidental injury, which may have provided enough evidence to place the matter before the courts.

4.7 Hospital staff identified that N's name was on the Child Protection Register when he presented in August 2006 but did not liaise with Children's Services before discharging him. He had a spiral fracture of the tibia at the time. This was identified by radiographers but not communicated to medical staff. Consequently the child protection network was not alerted. Although the parents gave an explanation consistent with accidental injury, this was a more serious injury than any previously reported. This would have heightened concerns, and might have prompted legal action.

4.8 This case again provides evidence of the link between domestic violence and child abuse. There should have been an attempt to work with N's mother individually on this.

4.9 There were instances when agencies could have worked more productively, individually and together. Children's Services did not fully follow up the second referral made to them in April 2006 and should have seen N more often in the last weeks of his life. The Police Child Abuse Investigation

Team did not maintain a consistent position in deciding which referrals required their involvement. Hospital staff should have liaised more proactively with community-based services. None of these instances impacted directly on his death, but they have been accepted as learning points by the agencies involved.

4.10 Serious Case Reviews scrutinise the actions of agencies and individuals in detail. It is important that instances of good practice or helpful interventions are recognised. The Serious Case Review drew attention to the following features in the conduct of the case.

- The grounds for concern about N were fully identified in the assessment and continuing work with the family.
- There was good management support and supervision of staff and specialist advisors were appropriately involved.
- Sound legal advice to assist the management of the case was promptly and consistently provided..
- A Health Visitor displayed enduring concern for N, and made sustained efforts to monitor his welfare.

5. Recommendations

5.1 All agencies have made detailed recommendations for internal action within their Management Reviews. They are not all repeated here. The most pressing of these recommendations relates to the development of guidance in relation to skeletal survey. This reflects the crucial difference skeletal survey would have made to the management of this case, and the inevitability that this issue will recur in other cases.

5.2 Recommendation to all agencies

5.2.1 All agencies should develop initiatives which demonstrate a continuing commitment to promoting good inter-agency communications.

5.3 Recommendations to the Havering Local Safeguarding Children's Board

5.3.1 The LSCB should remind staff in all local agencies that they

- should at all times be alert to potential safeguarding issues
- have a duty to share information appropriately in cases where the safeguarding of a child is at risk.
- have a responsibility to keep accurate records

5.3.2 The LSCB should review and strengthen local, multi-agency guidance on identifying and working with parents who are difficult to engage. This should include trigger points at which interventions can be escalated, and an emphasis on the need for all agencies proactively to seek evidence.

5.3.3 The LSCB should develop multi-agency guidance to inform decisions about when it is appropriate to conduct skeletal surveys

5.3.4 The LSCB should review and strengthen arrangements for the conduct of Core Groups, taking account of the multiple tasks which currently fall to the social worker, and the benefits of independent chairing in complex cases.

5.4 Recommendation to the Havering Local Safeguarding Children Board and the Havering Drug & Alcohol Action Team Board

5.4.1 The two Boards should arrange a joint assessment of local arrangements for children's services and substance misuse services to work successfully together.

5.5 Recommendation to Havering Children's Services and the Metropolitan Police Service

5.5.1 The two services should ensure that there is clarity and consensus about the arrangements for initiating, conducting and concluding joint investigations.

5.6 Recommendations to Havering Children's Services Department

5.6.1 Havering Children's Services Department should review its arrangements for receiving and processing referrals, to ensure that allegations of injury are identified and followed up in line with statutory requirements and procedural guidance.

5.7 Recommendations to the Metropolitan Police Service

5.7.1 The Metropolitan Police Service should ensure that partner agencies are clear about the nature and content of the police threshold policy for joint investigations.

5.7.2 The Metropolitan Police Service should reiterate to Territorial Police staff the arrangements for reporting and recording issues of domestic violence and child protection concerns.

5.8 Recommendations to Barking, Havering and Redbridge NHS Trust

5.8.1 The Trust must ensure that no child about whom there are child protection concerns is discharged from hospital without an identified GP, in line with Recommendation 72 of the Victoria Climbie Report.

5.8.2 The Trust should ensure that radiography staff are aware of their child protection responsibilities, that there are clear arrangements for transferring information between Radiography Departments and other service areas, and that these are regularly audited.

5.8.3 The Trust should ensure that there are sound arrangements for monitoring and reviewing the outcomes of all medical investigations into possible Neonatal Abstinence Syndrome, and sharing that information appropriately with community-based services

5.8.4 The Trust should re-issue guidance to all staff working in Accident and Emergency services about the actions to be taken when dealing with children for whom there is a Child Protection Plan.

5.8.5 The Trust should ensure that it makes sound arrangements for the convening, minuting and follow-up of any meetings relating to the safeguarding of children.

5.9 Recommendation to the Barking, Havering and Redbridge NHS Trust and the Havering Drug and Alcohol Action Team

5.9.1 The two agencies should review and strengthen guidance, and access to specialist advice, for staff in Maternity Services on working with parents who misuse drugs or alcohol, and babies born with Neonatal Abstinence Syndrome.

5.10 Recommendation to Havering Primary Care Trust

5.10.1 The Trust should ensure that the arrangements for compulsory allocation to General Practitioners are used as necessary to support the safeguarding of children

5.11 Recommendation to the London Borough of Havering

5.11.1 The London Borough of Havering should review its arrangements for liaison and co-operation between Departments in relation to anti-social behaviour, with particular reference to situations where there may also be child protection concerns