

Barnet Safeguarding Children Board

Serious Case Review Executive Summary

Child 'D'
aged 4 months at time of death

1. Reason for Serious Case Review

- 1.1. Child 'D' died at the age of 4 months. He had been made the subject of a child protection plan before his birth because of concerns about the exposure of his elder sibling to domestic abuse while in the care of his mother. His elder sibling was removed from his mother's care and placed for adoption.
- 1.2. His death has been investigated by the Police and the Coroner concluded that the cause of death was Sudden Infant Death Syndrome.

2. The terms of reference for the review

Agencies should include all relevant information, but in particular the review will focus on:

- 2.1. The hospital visit on 19th November 2008 when he was diagnosed with bronchiolitis and subsequent action.
- 2.2. The quality of information-sharing and communication within or between agencies.
- 2.3. How well the current risk factors were understood and whether the following issues were identified as potential risks to the child:
 - vulnerability to domestic violence
 - the sleeping arrangements and possible overheating
 - his mother's use of alcohol
 - smoking – including possible smoking indoors in the presence of Child 'D', with potential risks to the child
 - whether individual agencies were robust in their contact with Child 'D' and his mother and whether the above issues were addressed
- 2.4. The child protection plan – was it carried out and did it sufficiently identify the risks present for Child 'D'?
- 2.5. Was his mother appropriately referred to domestic violence services and were interventions effective?
- 2.6. Were policies and procedures in place and were they complied with (those of the BSCB and of individual agencies)?
- 2.7. Report writers should establish whether there are any issues which relate to ethnicity, faith or disability which may have a bearing on the review.

Additional terms of reference added once new information became available in March 2009 following the final post-mortem results:

- 2.8 There was a 'healing fracture' dating back at least 4 weeks prior to his death. In relation to this please revisit information from Child 'D's date of birth (18.07.08) to 28.10.08 to try to identify any events that may have caused the fracture. Please also revisit information from his birth to his death on 25th November 2008 to identify whether there were any signs or symptoms indicating the possibility of a fracture and whether the fracture could possibly have been identified by any professionals at any stage.
- 2.9 Child 'D' suffered some brain damage due to interruption of the blood supply to his brain at some time in his life. In relation to this issue, is there any information from the whole of his life span which could possibly have related to the brain damage indicated? If so, could this have been picked up by any professionals at any time?

3. Serious Case Review Panel

Name	Designation	Agency
Sally Trench	Chair	Independent
Alan Fuller	Principal Education Psychologist	Barnet Children's Service
Alison Dawes	Head of Access to Schools	Barnet Children's Service
Barry Rawlings	Safeguarding Adviser	Barnet Voluntary Service Council
Charlotte Gavin	Senior Probation Officer	London Probation Service
Fiona Jackson	Associate Director Operations: Children and Learning Disabilities Services	Barnet PCT
Kathleen Ely	Deputy Director of Healthcare Governance & Risk	Barnet PCT
Phil Morris	Divisional Manager, Safeguarding	Barnet Children's Service
Wendy Morgan	Detective Inspector, Barnet & Enfield CAIT	Metropolitan Police

4. Individual Management Reviews

Metropolitan Police, including Essex and Hertfordshire Police
London Probation Service
Barnet Children's Service
Barnet Housing Service
Barnet PCT

5. Reports to support the review process

Barnet and Chase Farm Hospital Trust
London Ambulance Service

6. Independent Overview Report Writer

- 6.1. This overview report has been undertaken by Donald McPhail, M.A.,M.Phil., CQSW, an independent consultant who has previously written several serious case review overview reports.

7. Family Background

- 7.1. Child 'D's mother had an unsettled childhood and was accommodated at the age of 15 by the local authority. Her first son was removed from her care in 2005 because of her inability to protect him from the impact of domestic abuse. She met Child 'D's father, about a year before he was born. In the timescale covered by this review it was established that he had perpetrated domestic abuse on a previous partner, including when she was pregnant.

8. Summary of agencies' involvement from the time Child 'D's mother's pregnancy

- 8.1. Child 'D's mother attended hospital on the 28th March 2008 with abdominal pains and it was established that she was 23 weeks pregnant. She was forthright in telling hospital staff about her previous contact with social services and the removal of her first son. She also stated that she was homeless and intended to separate from her partner.
- 8.2. The hospital midwife contacted the hospital social work team immediately and an initial assessment was undertaken on the 31st March. In the course of the assessment, it became known that her current partner had been violent towards his previous partner, including violence to her while she was pregnant. The hospital social worker informed her of this history and she decided to separate from him.

- 8.3. Child 'D's mother was seen by the Housing department on the 7th April to determine whether they considered they had a duty to house her because of homelessness. Subsequently, after Child 'D' birth, she was housed in a one bedroom flat in a council hostel.
- 8.4. In light of the history in relation to her first son being removed from Child 'D's mother's care, the hospital social work team called a legal planning meeting on the 30th April. It was concluded at that meeting that there were insufficient grounds to initiate care proceedings, but it was recommended that child protection procedures be followed. A pre-birth child protection conference was held on the 16th June and it was agreed that because of concerns about her history of engaging in relationships with partners who physically abused her, there was potential risk to the unborn child and it was agreed that the baby would have a child protection plan under the category of neglect.
- 8.5. Child 'D' was born on the 18th July and discharged from hospital on Sunday the 20th. His mother gave two addresses, one in Barnet and one in a neighbouring local authority. Child 'D's mother moved between the two areas for a short period, and although this complicated the follow up by the midwives and the social worker, they communicated well with staff in both areas and Child 'D' was seen to be developing well and perceived to be 'happy'.
- 8.6. On the 1st August, the community midwife visited and gave advice on contraception and on cot death prevention. Child 'D's mother was considered by the midwife to be fit for discharge from the midwifery service and the new birth visit was undertaken by the health visitor on the 4th August when the baby was considered to be well. The health visitor had raised the issue of co-sleeping and was assured by baby 'D's mother that she was not co-sleeping with her baby.
- 8.7. On the 17th August, Child 'D's mother was arrested for assault following an assault at a caravan park in Clacton. She contacted family members to look after the baby. She was charged with actual bodily harm and bailed.
- 8.8. On the 1st September Child 'D' had a 6-week check, and was considered to be a normal baby who was being bottle fed. A review child protection conference was held on the 1st September 2008. This conference was informed of good progress in his care, with him gaining weight and his mother being responsive to, and meeting, his needs.
- 8.9. A parenting assessment was undertaken between the 5th August and the 16th September, and concluded that there was a need for the baby to remain subject to a child protection plan and that his mother's capacity to meet his needs would need to continue to be assessed over time.

- 8.10. In the course of September, Child 'D's mother attended court on two occasions and was given suspended sentences on both occasions.
- 8.11. The second core group meeting was held on the 6th October when it was considered that Child 'D' was developing well. A third core group meeting was held on the 14th November. It was again reported that things were going well and the social worker and the health visitor encouraged Child 'D's mother to take the issues arising from the parenting assessment seriously.
- 8.12. Child 'D's mother took him to the Health walk-in centre on 19th November because of concerns about his chest. It was decided that he needed to be taken to the A&E department of the hospital and his mother was given a letter to take with her. They were taken by ambulance to the hospital.
- 8.13. At the hospital, he was referred to the paediatric assessment unit with bronchiolitic symptoms. He was examined by senior medical and nursing staff. He was treated for a respiratory infection and his mother was given advice on her smoking and sleeping arrangements. The administrative system in the hospital did not identify that he had a child protection plan, although this information was contained in the letter given by the walk in centre.
- 8.14. Child 'D' was seen by a consultant later in the day and was discharged home.

9. Circumstances of Child 'D's death

- 9.1. On the morning of the 25th November a member of staff in the hostel woke Child 'D's mother up when she knocked on the door, and it was then Child 'D's mother realised that there was something wrong with him and an ambulance was called. He was later pronounced dead.
- 9.2. The police investigation established that Child 'D' had slept in the same bed as his mother the night that he died. The senior police officer involved in the investigation searched the accommodation and concluded that there were no signs of neglect, that there was the smell of stale alcohol on the mother's breath, but that she was not drunk. There was also evidence of smoking with cigarette butts in the ashtray.
- 9.3. The event was treated as a Sudden Unexplained Death in Infancy and the rapid response protocol was initiated.
- 9.4. The coroner concluded that Child 'D' died of Sudden Infant Death Syndrome.

10. Findings

- 10.1. Knowledge of the potential risks inherent in this case was good across all professions, and there was clear understanding of the need for coordinated professional activity to assess and respond to the needs of the unborn baby.
- 10.2. Professionals were not guilty of the 'start again' mentality described in the Ofsted review of serious cases¹, and appropriately drew upon their knowledge of past concerns to inform the present situation.
- 10.3. Child 'D's mother demonstrated a willingness to work with professionals to an extent, but found it difficult when her child care practice in relation to sleeping and feeding was challenged.
- 10.4. The parenting assessment recognised that her compliance was qualified and that her parenting skills would need to be evaluated over time. This demonstrated a determination to remain focused on Child 'D's needs, in spite of resistance from his mother.
- 10.5. The information available to GP (1) on Child 'D's mother's obstetric history was totally dependent on her own account, as this was a new registration and the medical file had not yet been transferred. Although the GP recognised her vulnerability from the account she provided and made this known to the midwifery service, the system of information transfer did not support the GP in recognising the specific implications of her previous child having been removed.
- 10.6. Housing service appears not to have been perceived as a key partner in the child protection process and its role was underestimated by not being included in child protection conferences and core groups.
- 10.7. There was commitment to multi-agency cooperation for assessments and, although the structure of initial and core assessments and of child protection processes was in place, the specific procedural timescales for pre-birth assessments and child protection conferences were not adhered to. This was not challenged by any partner agencies.
- 10.8. Child 'D's father was not involved in any formal assessments. His mother broke off her relationship with him when she was informed of his previous violence and he was not involved with the birth or with Child 'D' at any time. This focus on mothers was a finding of the Ofsted review of serious case reviews².

¹ 'Learning Lesson, taking action : Ofsted's evaluation of serious case reviews 1 April 2007 to 31 March 2008'

² 'Learning Lesson, taking action : Ofsted's evaluation of serious case reviews 1 April 2007 to 31 March 2008'

- 10.9. The initial and review child protection conferences did not have optimum membership and this limited their effectiveness. With particular reference to the review child protection conference, the membership seemed to dictate the focus of conference concern. Neither Police nor Probation were in attendance, and although the Police had provided information about Child 'D's mother's forthcoming court appearances, their significance in respect of the real possibility of her receiving a custodial sentence, appears not to have been understood. The Housing Service was not invited either.
 - 10.10. Advice on avoiding sudden infant death was provided routinely to Child 'D's mother by health care professionals. As there were identified risk factors and due to the misleading information that she gave to health staff, there was an added focus on providing information about SIDS to her. There is a need to ensure that the children's workforce as a whole understands the issues and is able to communicate agreed and coordinated messages from different professional perspectives.
 - 10.11. It is not clear whether sufficient prominence was given to meeting Child 'D's mother's emotional needs. Her family history, her history in care, and her experience of the removal of her first son, clearly influenced her perceptions and attitudes. These basic requirements needed to have been addressed before she would have been able to overcome her resistance to professional advice to improve her parenting capacity.
 - 10.12. It is clear that Child 'D's mother was fully involved in assessment and decision making processes, and there was open and honest communication with her.
 - 10.13. The social worker acted swiftly to ensure that Child 'D's mother was aware of safety issues when it became known that her then current partner had a history of domestic abuse, but there was also a need to develop a strategy with her to ensure that she did not expose herself to further risk when she terminated her relationship with him.
 - 10.14. Although robust child protection plans were established at the child protection conferences, the relationship to the core group meetings did not appear to be strong. There is an expectation that the core group develops and implements the outline child protection plan from the child protection conference, but the core group meeting seemed to be used more as a forum for professionals to report to one another. In addition, it is not clear that the review child protection conference held the core group to account for aspects of the outline child protection plan that were agreed at the pre-birth child protection conference but were not implemented.
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- 10.15. Although there was a birth plan to address how the hospital should manage the aftermath of his birth, Child 'D's mother's request to be discharged on a Sunday, when the midwife could not make contact with the social worker, caused initial uncertainty until contact was made with the child protection midwife. Such a plan needs to be detailed enough to cover the contingencies that arise from the provision of 24-hour 7-day-a-week care in hospital.
- 10.16. If the plan is to include refusing to agree to a parent removing a child, legal advice is required to ensure that any restriction of liberty is based on legal authority.
- 10.17. The system for flagging up children with child protection plans did not lead to the A&E department or walk-in centre identifying that Child 'D' was a child with a child protection plan. It is a key element of local strategy to identify risk to children, and the system needs to be reviewed to establish if it is, or can be made more, effective.
- 10.18. While Child 'D's mother expressed concern about the care she had been given as a child, it was also clear that she robustly defended child care practices that emanated from her family. Information was not provided in the course of this review on the support that she was given as a child in care in preparation for her future role as a parent. Consideration needs to be given to whether sufficient attention is being given to supporting the development of positive parenting for young people in care.

11. Conclusion

- 11.1. 'Child D's death was a sudden unexplained death in infancy. Although risk factors were present, the coroner did not identify any as contributing to the death.
- 11.2. The main factor that lay behind the child protection plan for Child 'D' was concern about his mother re-engaging in a relationship where domestic violence was a factor and it is clear that actions taken by agencies supported her disengagement from one potentially violent relationship. As she did not seek to have another relationship in the timescale of his review, whether she achieved sufficient insight into avoiding such relationships in the future is untested.
- 11.3. This review has identified that advice was given on many occasions to Child 'D's mother about co-sleeping as a preventative factor, but only one professional knew that she did (sometimes) co-sleep with him.
- 11.4. It cannot be concluded that advice given more robustly by individuals or more consistently by all professionals would have caused Child 'D's mother to change his sleeping arrangements.

- 11.5. It is clear however, that there is a need for a concerted and assertive approach to providing advice by all professionals on avoiding the factors that can contribute to an unexplained death in infancy.
- 11.6. On the information presented to this review, it appears that no agency was in a position to identify the fracture and the interruption to the blood supply that were eventually identified by the post-mortem.
- 11.7. As detailed in section 12 above, there are many examples of good practice in this review and it is clear that professionals cooperated well and remained focused on Child 'D's needs.

12. Recommendations

All individual management reviews included agency recommendations (see 18 below), and the overview makes the following additional recommendations:

- 12.1. The LSCB should audit the invitations to, and attendance of, agencies to child protection conferences to establish whether the guidance contained in the London Child Protection Procedures is being complied with.
- 12.2. The LSCB should remind all agencies of the timescales that are set out in the London Child Protection Procedures for pre-birth child protection conferences.
- 12.3. The LSCB should ensure that core groups are fulfilling their functions as set out in the London Child Protection Procedures.
- 12.4. The LSCB should ensure that guidance is made available to the hospital on the plan that is required to be in place for the birth of any child subject to a child protection plan.
- 12.5. The LSCB should ensure that all agencies of the Board receive a briefing paper on SIDS, including what advice to give to parents.
- 12.6. The LSCB should consider how best to communicate with parents on the prevention of SIDS.
- 12.7. Children's Social Care should ensure that assessments engage with fathers as well as mothers.
- 12.8. Children's Social Care should review the support they provide to young people in care to assist them in developing positive partner relationships parenting skills for their future role as parents .

13. Individual Management Review Recommendations

13.1. Barnet PCT

1	All members of Barnet Community Service Children and Families Team should use a pre CAF assessment when completing the new birth visit.
2	Consideration should be given to a risk assessment model which would identify vulnerabilities within families and strengths and weaknesses.
3	Child protection supervision for health visitors / school nurses needs to take place following attendance at initial case conference.
4	A training update should be provided on record keeping within Barnet Community Service Children and Families Team to identify issues raised within this review.
5	Training should also highlight the importance of information sharing and links between the Barnet Community Service Children and Families Team and general practice and midwifery services.
6	Where previous domestic violence has occurred, consideration should be given as to whether a referral to MARAC (Multi-agency risk assessment conference) or to Elevate would be of use.
7	The flag-up system for children subject to a child protection plan in both Barnet Hospital and Finchley and Edgware Walk in Centre should be reviewed. We endorse the recommendations suggested by Barnet and Chase Farm in their contributing report regarding this issue.
8	<p>London Ambulance Service should be supported, if required, in the discussion with London Safeguarding Board regarding access to names of children subject to safeguarding children plans.</p> <p>Liaison to be affected with London Safeguarding Board to explore:</p> <p>a) Improved liaison and sharing of info between local authorities and the LAS in relation to children identified as being 'at risk'</p> <p>b) Guidance in relation to the totality of information required to enable ambulance services to provide comprehensive info to safeguarding investigations</p> <p>c) The introduction of a standard enquiry format which is both more easily completed and takes into account the patient / emergency care interaction</p>
9	Midwives need to ensure any discrepancies in obstetric history should be clarified with the client and GP and documented.
10	The process for creating clinical notes folders for new borns across the Trust needs to be reviewed.

11	Continue to update and refresh midwifery and obstetric teams regarding actioning of alerts and child protection issues via study days and unit meetings.
12	Neonatal notes have been revised to include a prompt for staff to check social concerns prior to discharge home of newborns. This system is to be highlighted at future training in maternity and paediatric departments.
13	Training is required for A&E receptionist staff, to include checking if infants/ children have previously attended Barnet or Chase Farm hospitals and where the infant was born to prevent the creation of two MRN (medical record numbers)
14	Ongoing liaison with IT department is required to address concerns regarding registration and production of duplicate MRNs on the Patient Administration System'
15	Child Death procedures training for A&E staff to be incorporated into safeguarding training and include use of Child Death Pathway.
16	All potential IMR authors to request and access training in IMRs from the Local Safeguarding Children Board.

13.2. Barnet Children's Service

1	Ensure that CP plans specify that formal parenting assessments explore risks relating to parental alcohol and substance misuse, where these risks feature in a parent's recent history. This information can then be reviewed at subsequent child protection conferences.
2	Social work case notes should clearly distinguish between announced and unannounced statutory visits and line managers are to ensure that announced visits take place as per the CP plan. This can be monitored via management file audits and at CP review conferences.
3	Social workers to refer to specialist domestic violence support agencies to help address a parent's assessed vulnerability of becoming involved in future violent relationships.
4	Local protocol between Children's Service, BCFH Trust, and the PCT (re walk-in centres) concerning flagging of all children subject to CP plans on hospital records should be reviewed. This is to ensure that Children's Service is notified of all hospital visits involving children subject to a CP plan. The LCSB Standards Group to carry out spot checks to monitor whether the system is working effectively.

5	All social workers within the Children's Service to be offered training and access to current research and literature regarding safe infant sleeping practices. Social work team managers to monitor this via the staff appraisal system and training to be commissioned by Barnet's Children's Workforce Development Team, in conjunction with the LCSB Training sub group.
6	Joint guidance and protocol to be developed between Children's Service, BCFH Trust and the PCT to support social workers in jointly working with midwives and health visitors to promote safe infant sleeping practices and ensure that these are being robustly monitored. CP leads from Children's Service, BCFH Trust and the PCT to develop protocol and gain endorsement from the LCSB.

13.3. Barnet Housing

1	Housing, where involved, to be included in CP conferences, core groups and other meetings to discuss families' needs where a protection plan is in place.
2	Housing staff working with new parents should be trained and have publicity materials about the dangers of co-sleeping.

13.4. Probation Service

1	Senior Probation Officers to reinforce to all staff the requirement to complete initial sentence plans within timescales set out in National Standards. SPO`s to monitor through work reviews with staff. For immediate implementation, and monitoring will be on-going.
2	Senior Probation Officers to reinforce to all staff the importance of applying LP recording convention and in particular the requirement to ensure records are accurate, and reflect all key activity undertaken in relation to a case, including liaison with other agencies. SPO`s to notify ACO when Teams have been briefed in relation to the recording convention. To be implemented by 27 th February 2009.
3	LP revised and updated Safeguarding Children practice guidelines reissued in December 2008. ACO re-issued again in February 2009.

13.5. Police

1	It is recommended that Barnet BOCU officers, including supervising staff, must be reminded of the contents of Territorial Police Safeguarding
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	Children Standard Operating Procedures (SOPs) to remind officers of the thresholds to complete MERLIN/PACs, with particular reference to pregnancy and the risk to the unborn child.
2	It is recommended that Barnet BOCU should carry out an audit to ensure that they are ECM compliant in respect of incidents that require a MERLIN/PAC.
3	It is recommended that Enfield BOCU officers, including supervising staff, must be reminded of the contents of Territorial Police Safeguarding Children Standard Operating Procedures (SOPs) to remind officers of the thresholds to complete MERLIN/PACs, with particular reference to pregnancy and the risk to the unborn child.
4	It is recommended that Enfield BOCU should carry out an audit to ensure that they are ECM compliant in respect of incidents that require a MERLIN/PAC to be completed.
5	It is recommended that Essex Police produce a new system (<i>computer based or paper format</i>) for officers to complete when in contact with children, and child protection concerns are raised, to share this information, (where appropriate) with partner agencies in the support of 'Every Child Matters'.
6	It is recommended that Essex Police produce 'Procedural Guidelines' (<i>in support of any new system introduced</i>) to inform officers who have contact with children and concerns are identified, of what action must be taken in the support of 'Every Child Matters'.
7	It is recommended that Enfield BOCU should review their procedures where a person has been arrested and is circulated as wanted to ensure that the suspect is dealt with promptly. The policy should include the recording of a rationale where it is not possible to deal with the suspect at that time.

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