Alexander Gallon (also known as Alexander Wails)

Executive Summary of the Overview report

The aim of the Executive Summary is to provide a balanced and coherent overview of the full Report (the Overview Report), including its recommendations, without disclosing any of the sensitive information contained in that report. It should address as far as possible public interest issues of accountability and transparency without compromising the confidentiality of the review.

1. INFORMATION ABOUT THE REVIEW PROCESS

The following agencies submitted Single Agency Reports to the Serious Case Review:

The Health Service
(Newcastle, North Tyneside and Northumberland NHS Mental Health Trust submitted a Serious Untoward Incident Report)
Newcastle Social Services Directorate
Barnardo's
St Cuthbert's Care
Northumbria Police

An independent person was commissioned by the Local Safeguarding Children Board to write an Overview Report which would:

- Bring together and draw overall conclusions from the information and analysis contained in each of the Single Agency Review Reports and
- Make focused and specific recommendations capable of being implemented

This Executive Summary has been drafted by the author of the Overview Report. It summarises the key issues arising from the case and lists all the recommendations made within the Overview Report, which include those from each Single Agency Report.

Agreed by Serious Case Review Committee on 20.09.2006
Agreed by Newcastle Local Safeguarding Children Board on 10.10.2006

2. KEY ISSUES ARISING FROM THE CASE

2.1 Summary of the facts contained in the Overview Report

2.1.1 Alexander Gallon was born on 19 April 2005. His parents were Danielle Wails and Robert Gallon. Alexander died on 28 August 2005 following a fire at his mother's home. She has been charged with his murder and pleaded guilty to infanticide.

2.1.2 Prior to becoming pregnant with Alexander, Danielle Wails had been known to the health service through self referrals regarding her feelings of depression. She did not comply with the advice and treatment offered to her.

2.1.3 Her pregnancy with Alexander was "unplanned but wanted". Her relationship with Alexander's father was volatile.

2.1.4 Throughout her pregnancy, and following Alexander's birth, Danielle Wails experienced problems relating to her health, accommodation and finance.

2.1.5 As a result of these problems she was referred by her health visitor to Social Services in March 2005 and to a specialist mental health team in May 2005.

2.1.6 In March 2005 a friend referred Danielle Wails to a service run by Barnardo's which works with young people who are in housing need.

2.1.7 A worker at Barnardo's referred her to St Cuthbert's Care, who have a project providing short term tenancies for single women and their children. Danielle Wails and Alexander moved into one of the tenancies in July 2005. It was at this accommodation that Alexander died.

2.1.8 Until his death Alexander had been a well cared for, healthy baby.

2.2 Summary of findings (i.e. analysis of the facts) of the Overview Report

2.2.1 Danielle Wails was a young woman coping with problems relating to her mental health, her relationships with men, accommodation and finance. She routinely approached agencies, particularly within the health service, to ask for help, but rejected the advice and support offered.

2.2.2 Staff with whom she spoke were prepared to accept the problem she presented with and attempted to address them but did not explore in more depth the underlying issues affecting this young mother. Clients who are difficult to engage present a challenge to all agencies but a pattern of behaviour which includes repeated requests for help and repeated rejection of that help should prompt further investigation. This is especially relevant when a child, particularly a young baby, is involved.

2.2.3 Communication between staff in all agencies involved who saw Danielle Wails was limited.

2.2.4 Recording systems within the Social Services Directorate and within the primary health care team, which contained significant information about Danielle Wails, were not easily accessible to staff working in either setting who had contact with her.

2.2.5 Despite the indications of risk to Alexander, which are evident with the benefit of hindsight, it should be acknowledged that he had been a wanted and well cared for baby. His mother was selective in deciding which information she divulged to each agency and in deciding which help she would accept. It is difficult to identify a point in Alexander's life when the level of risk he faced would have been apparent to staff working with Danielle Wails. Had she been confronted with any concerns about her ability to care for her child it is unlikely, on the basis of her previous behaviour, that she would have accepted any help offered.

2.2.6 The events which led to Alexander's death were unpredictable and, as such, could not have been prevented. There was nothing within Danielle Wails' behaviour which would have led anyone to believe she would have killed her child in this manner.

3. SUMMARY OF THE LESSONS TO BE LEARNED FROM THIS CASE

3.1 Individuals who make frequent contact with agencies to seek help, but who then reject the help offered, should alert those professionals involved. "Difficult to engage" clients present a challenge to all agencies but such behaviour should prompt further investigation.

3.2 Professionals should look beyond the problem presented to them by the client. In this case Danielle Wails was regarded by three agencies to which she was referred as in need of practical assistance with housing and finance. This should have prompted a more thorough assessment.

3.3 Danielle Wails was seen by the health service during her pregnancy with symptoms resulting from drinking excess alcohol, the implications for the care of her unborn child were not acted upon. In any case where there is an expectant mother the safety of the child must be paramount.

3.4 After his birth Alexander was regarded as a well cared for baby but the implications of his mother's behaviour for his future safety were not analysed. In any situation where there is a child/children the safety of that child/children must be paramount.

3.5 The well known link between domestic violence and risk to children must be acknowledged by professionals who are called to deal with incidents of domestic violence.

3.6 All professionals must ensure they establish and maintain effective communication, and communication systems, both between agencies and within agencies.

3.7 The systems put in place following the Laming Report should be complied with by all agencies. In this case those recommendations relating to case management and the supervision of staff are particularly relevant.

4. RECOMMENDATIONS

4.1 Recommendations from the Single Agency Reports

4.1.1 To the health service:

4.1.1.1 All nurses and midwives working in primary care have training in use of IT systems in order to access and share information.
December 2006

4.1.1.2 Duplicate record keeping to cease within GP surgeries, i.e. the use of Lloyd George (i.e. paper) records when computerised systems are in place.
Achieved

4.1.1.3 GP practices should have a protocol relating to access of their systems and responsibilities for capturing concerns/social history.
December 2006

4.1.1.4 Antenatal Cause for Concern criteria to be reviewed and forms to be completed as per guidelines.
Achieved

4.1.1.5 A screening tool to be used for detection of mental health problems in antenatal clients and a "pathway of care" to be developed.
Achieved

4.1.1.6 A comprehensive "locum pack" to be provided to all locum GPs to ensure a standardised approach to referrals.
Achieved

4.1.1.7 GPs to have access to team/individual supervision sessions and to annual updates in child protection.
Achieved

4.1.1.8 Accident and Emergency department to have a robust system in place to ensure the safeguarding and protection of unborn babies by contacting the community midwives if concerns arise, as soon as possible.
Achieved

N.B. None of the above recommendations were directed to specific Trusts or included any time scales for implementation. The implications will affect all the trusts who had staff who worked with Danielle Wails; Newcastle Primary Care Trust; Newcastle Acute Hospitals Trust and Newcastle, North Tyneside and Northumberland Mental Health Trust.

From the mental health report, to Newcastle, North Tyneside and Northumberland NHS Mental Health Trust

(The following is written in accordance with the Serious Untoward Incident reporting requirement of the production of an action plan)

4.1.1.9 Perinatal team should include sentence "If you feel further action is required could you please advise me accordingly" in all discharge letters to GPs.
Achieved

4.1.1.10 Perinatal team should conduct an audit of random notes looking at discharge policy and trajectory.
October 2006

4.1.1.11 Subject to the restrictions of sub judice the Trust should emphasise that client disclosing recent physical violence to others should be thoroughly assessed on this specific point, being mindful of general issues of dangerousness and the safe guarding of children.
Achieved

The action plan:

- To ensure reports/documents are copied to appropriate professionals.
  Achieved

- Copy discharge letter to referrer and /or GP so that they are aware that services are no longer involved.
  Achieved

- Ensure assessment letters and reports are filed in clinical notes.
  Achieved

- Ensure notes in the Perinatal Service are compliant with Trust's Did Not Attend and Difficult to Engage Service Users Policies.
  October 2006

- Training needs analysis of Perinatal Team around forensic issues, child protection and infanticide.
  Achieved

4.1.2 To the Social Services Directorate

Collecting and interpreting information

4.1.2.1 Before any home visits take place, a check on all available information known about the child, the child's parents/carers should be carried out by the visiting worker. This must include reading historical files and obtaining information held by other agencies. This information would be fully incorporated into any assessment. (Laming recommendation 34)
Immediately

4.1.2.2 Social work assessments should always accurately include information held by other agencies to more accurately reflect risk. The production of comprehensive family assessments, including male figures, is imperative.
(Laming recommendation 34)
Immediately

4.1.2.3 Social Care Assessment Officers should not be given initial assessments to complete. The identification of any child protection issues should be made by a worker qualified and knowledgeable in

this area. This is especially relevant when the children are under 3 years old. (Laming recommendations 20 and 52)
Immediately

4.1.2.4 The allocation of a case referred to the Customer Service Team should be to a named worker, who would be responsible for meeting timescales and the progress of the case. (Laming recommendation 19)
December 2005

4.1.2.5 The case should not be closed on behalf of the Team Manager by clerical staff. All assessments and recommendations should be read by the Team Manager before closure occurs. (Laming recommendation 26)
December 2005

4.1.2.6 Commissioning Managers may wish to open dialogue with staff on the merits or otherwise of the CareFirst recording system and what useful adjustments could be made to make the system more relevant to the social work task.
December 2005

Procedures

4.1.2.7 Every child's case file must include a properly maintained chronology and this should be started on the day a first referral is received. It should be easily located, on the inside of the file's front cover, and be added to as each activity is undertaken. (Laming recommendation 58)
Immediately

4.1.2.8 Any letters sent out by the Customer Service Teams should be signed and bear the name of the sender; they should not just be from a "duty social worker".
Immediately

Interagency working

4.1.2.9 Social workers completing any assessment should have an ongoing dialogue with all other professionals involved in the case. The case should not be closed until this has occurred. (Newcastle Children's Services Practical Guide for Social Work Staff)
Immediately

Training and Supervision

4.1.2.10 Social work staff should receive training in the completion of Initial and Child Protection Assessments, particularly in the area of assessing risk.
(Laming recommendation 31)
June 2006

4.1.2.11 Team Managers should ensure that all staff are offered regular formal supervision, which should cover each case for which the social worker is responsible. (Children's Services Procedures)
(Laming recommendation 45)
Immediately

4.1.2.12 When allocating a case to a social worker, the manager must ensure that the social worker is clear as to what has been allocated, what action is required and how that action will be reviewed and supervised. (Laming recommendation 53)
Immediately

4.1.2.13 All Social Services Assessments of children and families and any action plans drawn up as a result must be approved in writing by a manager. (Children's Services Procedures) (Laming recommendation 25)
Immediately

4.1.2.14 Customer Service Teams need to have systems in place which enable the Team Manager to establish what action has been taken for each child, who is responsible for taking that action, and when that action must be completed. (Laming recommendation19)
January 2006

4.1.2.15 The recommendations approved as a result of this Single Agency review are disseminated to all Social Work staff via training and supervision.
January 2006

4.1.3 To Barnardo's

4.1.3.1 That the service establish a system for daily monitoring for missed calls to staff from mobile calls.
Achieved

4.1.3.2 That the agency draws up a pro forma to be used routinely by workers to inform other professionals of their involvement with potentially vulnerable young people and their role.

Achieved

4.1.3.3 There are already plans for a safeguarding event within the service to address single agency training needs. The effectiveness of the training should be reviewed on a regular basis through supervision, sampling of records and reviews.
Achieved

The single agency report author has also commented upon the need to review housing options available to young parents through Housing Pathway planning. It is also noted in the report that the case highlights the need for Common Assessment framework to be implemented and used in Newcastle, and that this has interagency training implications.

4.1.4 To the police

4.1.4.1 It is recommended that Northumbria Police policy be amended to remove any perceived discretion on the part of officers attending DV incidents as to when child concern notifications are submitted. It should be clearly stated that, because of the reasons outlined above, officers should submit notifications when children are part of a household where a domestic incident has taken place and whether they were present at the time of the incident or not.
Achieved

4.1.4.2 It is also recommended that the control rooms instruct their staff to code all domestic violence incidents where children are mentioned as being involved, or as part of the household, as child concern incidents. This will allow CPU supervision to ensure that notifications are submitted.
Achieved

4.1.4.3 Training sessions have already been undertaken and will continue at regular intervals in Newcastle to raise awareness of domestic violence and its impact on children.
Achieved

No timescales are included but it is recommended from the Overview report that the first two recommendations are implemented immediately.

4.1.5 To St Cuthbert's Care

4.1.5.1 No recommendation was made, however the following statement was received:

St Cuthbert's Care referral process states that referrals must be made by professionals; we do not accept self-referrals. Where there are any gaps in information or clarification is required, this is addressed with the referrer. Should the referrer state that there is social services involvement, the relevant social worker will be contacted for further information. In this particular case, the referrer stated that there was no social services involvement. As it appears this information was incorrect, it is recommended that the housing project contact social services for every referral regardless of the status declared by the referrer.
Achieved

4.2 Recommendations from the Overview Report:

4.2.1 To the health service

4.2.1.1 That the designated child protection professionals for Newcastle meet with the approved child protection professionals from each Trust to draw up an action plan to address the recommendations from the single agency report, allocate responsibility within each Trust to implement the work required and set realistic time scales within which to complete the work.
October 2006

To Newcastle Primary Care Trust;

4.2.1.2 The importance of primary care practice meetings, at which concerns over specific patients may be discussed, should be stressed to each primary care team. The lessons learnt about effective communication, the problems in the use of duplicate recording systems and the lack of face to face discussion between health care professionals which have been highlighted in this case should be included within whatever correspondence is sent to primary care teams.
December 2005

4.2.1.3 That the risk indicated by the failure of a parent to register a baby with a GP is acknowledged and systems be developed within primary care teams to encourage registration.
October 2006

To Newcastle, North Tyneside and Northumberland NHS Mental Health Trust;

4.2.1.4 To review the discharge policy of the Perinatal Mental Health Service in relation to those patients who have not engaged with services and

who, at the point of initial assessment, are thought to require the treatment offered. The safety of the child concerned should take precedence and any information relevant to this should be shared with other professionals caring for the patient.
Achieved

To Newcastle, North Tyneside and Northumberland NHS Mental Health Trust:

4.2.1.5 To review the use of the Critical Outcomes and Routine Evaluation (CORE) assessment forms by the Perinatal service.
Achieved

To Northumberland, Tyne and Wear Strategic Health Authority and to Newcastle, North Tyneside and Northumberland NHS Mental Health Trust

4.2.1.6 That in any case where a Serious Case Review is to be conducted, and in which the mental health services have been involved and are required to conduct an Untoward Incident Report, the two processes should be combined in order to produce one report to inform the Serious Case Review. Staff who had direct contact with the patient should always be seen and interviewed in person rather than information be gathered over the telephone.
Achieved

4.2.2 To St Cuthbert's Care

4.2.2.1 There should be a review of the child protection awareness of all project staff who work in housing projects providing tenancies for single mothers. This should include their understanding of indicators of risk and the threshold for requesting help for the tenants and their children.
Work is in progress

4.3 Recommendations from the Serious Case Review Committee

None recommended.

4.4 Recommendations from the Local Safeguarding Children Board

None recommended.

Catherine Weightman
August 2006