Devon Safeguarding Children Board

LSCB SCR CN04

Serious Case Review. Overview Report Executive Summary

In respect of Subject.

Born 2002, died April 2007 (Age 4 at death)

N.B. As a consequence of evaluation of this Serious Case Review by Ofsted the Overview Report is currently subject to review, which may require future amendments to this Executive Summary.

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April 2008

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Foreword.

1). This Executive Summary has been prepared to provide a succinct and accessible summary of a Serious Case Review (SCR) undertaken by the Devon Local Safeguarding Children Board (LSCB). The report gives a summary of the reasons for the SCR, the methodology used, the lessons learned and the recommendations made. It is a publicly available document that will be published on the Devon LSCB website at;

http://www.devon.gov.uk/index/cyps/child-protection/devonlscboard.htm

2). On 29th April 2007 Subject age 4 was being cared for by his maternal grandmother, (MGM), at her home in Exeter. An incident occurred there involving BM, Subject's mother. This resulted in the death of Subject and MGM sustaining serious knife wounds.
BM was subsequently arrested by the Police and detained in a secure psychiatric unit under the 1983 Mental Health Act.

3). BM and her family have been known to a range of agencies shortly before her birth in 1983. BM and her sisters had three separate episodes on Devon's Child Protection Register between 29th May 1986 - 30th Jan 1987, 28th April 1988 – 6th March 1990, and12th April 1995 - 4th Dec 1995. On differing occasions registration was in the categories of on physical abuse, likely sexual abuse, and emotional abuse. The latter consisted of exposure to domestic violence and being in the centre of a long running, acrimonious dispute between their separated parents.

4). On Jan 24th 2006 Subject's name was placed on the Child Protection Register in the category of neglect because of concerns about the standard of parenting being provided by his mother. A major component of the child protection plan was that Subject was placed periodically with his grandmother. This was at times when it was felt Subject was not receiving an acceptable level of care due to his mother's mental health. It included periods when she had been admitted as an in patient to a psychiatric ward. At the time of Subject's death he was again residing with MGM, his grandmother, under the auspices of the child protection plan.

5). Immediately following the incident of April 29th 2007 a Police criminal investigation was initiated into the circumstances surrounding Subject's death. In addition to this a Police investigation was also commenced into the conduct of the professionals and agencies that had been involved with Subject. This was to establish whether there had been any failing or culpability on the part of any individual or agency that might constitute a criminal offence.

6). Devon and Cornwall Police completed their enquiries by June 2007 and were satisfied that there did not appear to be any significant failings either by individuals or agencies that would make further criminal investigations justified. The investigating officer commented favourably on the co-operation offered him by the agencies and on the quality of the paperwork provided, to the extent that it was not necessary to interview any members of staff.

7). Following the completion of this investigation, the Devon Safeguarding Children Board considered the circumstances surrounding Subject's death and determined that the criteria are met for a Serious Case Review as required by Chapter 8 of the National Guidance "Working Together to Protect Children (2006)." This is on the basis that a child has died and abuse or neglect is known or suspected to be a factor in the death of the child.

Methodology.

8). This Review is undertaken in line with the Serious Case Review in the Working Together Procedure of 2006. It looks openly and critically at individual and organisational practise to see whether changes should be made and of so identify how such changes will be brought about.

9). In producing this overview report the following resources have been used. Agency Management Reports have been received from:-

- Devon County Council Children and Young People's Service. (Devon CYPS).
- Devon CYPS – Education Welfare Dept.
- Devon Primary Care Trust. (Local GP Practice).
- Devon Primary Care Trust. Health Visiting Services
- Devon Partnership NHS Trust – Mental Health Services
- South Western Ambulance Service.
- NHS Direct.
- EDP Drug and Alcohol Services.
- Royal Devon and Exeter Hospital Trust.
- Devon and Cornwall Constabulary.

10). A combined chronology has been constructed based on the involvement of all the agencies.

11). The Child Protection Conference minutes have been read relating to both BM and her sisters and to Subject.

12). Various methodologies have been used by the different agencies in compiling their reports. The Devon Primary Care Trust GP Service, and the Devon Partnership NHS Trust – Mental Health Services, interviewed relevant staff, perused medical and clinical records, and considered internal policies. The other agencies used data base information, file records and a consideration of internal and child protection policies in producing their report.

Terms of Reference.

13). For each agency to provide a view with regard to the robustness of the formal Child Protection Plan that Subject was subject to as a consequence of him being placed on Devon's Child Protection Register.
14).To establish whether each agency fulfilled all its responsibilities and actions as required by the formal Child Protection Plan relating to Subject.
15). To describe what assessment were undertaken of BM by each agency relation to her parenting ability.
16). To establish whether or not these assessments took account of the unpredictable nature of her mental illness and the implications of this with regard to her supervised or unsupervised contact with Subject.
17) To confirm whether or not each agency had concerns that BM would deliberately harm Subject or any other child.
18) To confirm whether each agency undertook or contributed to any assessment of the ability of MGM to provide alternative and safe family care for Subject. If so what was the opinion of each agency in this respect?
19) To describe all communication, information sharing and assessment processes undertaken by each agency.

Family Composition.

Subject Died April 2007 (age 4).

Mother The mother Age 23 in April 2007
Father The father Age 33 in April 2007

Maternal Grandmother
Maternal Aunts Maternal Aunt 1 (Age 22 in April 2007)
Maternal Aunt 2 (Age 21 in April 2007)
Maternal Aunt 3 (Age 16 in April 2007)
Maternal great grandmother

Maternal Grandfather.
Wife of Maternal Grandfather.
Their children are GFC1 (Age 17 in April 2007)
GFC2 (Age 15 in April 2007)
GFC3 (Age 13 in April 2007)

Lessons Learnt.

These are considered from a multi agency perspective.

20). The importance of consistent interagency communication between child care and mental health services, both verbal and written, when providing a service for parents with long term mental health issues. There are some good examples of effective liaison between CYPS and Devon Partnership Trust in

this case, but there were also times when this was poorer in quality and planning was not co-ordinated.

21). It is essential that the Child Protection Procedures are adhered to by all agencies. Each agency has to be aware of and prepared to act on its responsibilities within the procedures. There were various deficiencies that hindered the monitoring or planning for Subject once he was on the Child Protection Register. e.g. Lack of Core Groups, failure of some agencies to attend both Core Groups and Conferences, failure to provide reports to Conferences, reports in the incorrect format, lack of assessments asked for within statutory timeframes.

22). Key assessments need to be completed within a meaningful time frame so they can be used in decision making. In this case the Core Assessment was not available in written form after a year of Subject being on the Child Protection Register. There are several reasons claimed why this occurred. It should be remembered if a parent does not effectively engage in an assessment process without good reason, it is not unreasonable to draw the inference that they are not able to adequately work in partnership.

23). The importance of Line Managers of all agencies intervening early in the child protection process, if staff for whatever reasons, are unable to fulfil key tasks.

24). This case shows the need for the child protection process to include fully the Drug and Alcohol Services when they are involved with patients whose children have a Child Protection Plan. Equally the Drug and Alcohol Services must be proactive in initiating contact as soon as they are aware a child has a Child Protection Plan or when they have concerns about a patient's parenting.

25). Whilst an assessment of the maternal grandmother was completed in a reasonable timescale, the material consulted is unclear. Given her contentious history this is an important area. There is probably a need for CYPS to develop a more consistent approach in kinship care assessments in respect of process, format and issues to be considered.

26). The complexities of the current Devon Partnership Trust structure may have contributed to a less than coherent service being offered to BM. This includes the numbers and team structuring of the different staff involved, their access to her mental health history through medical notes, and the quality and relevance of risk assessments undertaken with her.

27). It would appear Devon Partnership Trust would benefit from reviewing it's child protection policies, staff understanding of how these should be implemented and the type of training need to ensure that this consistently occurs.

28). All agencies showed difficulty interpreting the likely level of risk to Subject when BM was unwell and including him in her dysfunctional thoughts. All

agency staff need some basic understanding of suicidal ideation and how to access further advice about individual patients.

29). The recording systems of most of the agencies reveal scope for improvement in content, accessibility or format. A key issue is the ability of staff to interpret and analyse a current situation in the light of previous behaviour.

30). It would appear there are ways of improving the quality of communication and feedback between RDE Hospital Trusts, GPs, Health Visitors and CYPS. Forms describing patient contact need to become routine and part of accepted practise.

Recommendations.

Devon Children and Young Person's Service.(CYPS)

31). Devon CYPS should ensure that kinship care assessments are completed using the agreed format and should be done to the same standard as a fostering assessments.

32). Devon CYPS should audit the number of kinship care assessments they undertake internally or outsource per year.

33). CYPS Managers must ensure compliance in relation to:

a) Child Protection Core Group meetings must be organised by the social worker at intervals agreed at the Child Protection Case Conference/Review and these meetings should be recorded in an agreed format and all members of the Core Group should attend.
b) The key worker must make contact with all agencies providing a service to parents where their child is subject to a formal Child Protection Plan.
c) All appropriate agencies providing a service should be sent minutes of Child Protection Conferences and invited to the next meeting.
d) A child with a Child Protection Plan must be seen within the timescales set down by the Child Protection procedures.

34). Assessments asked for at Child Protection Case conferences need to be completed within agreed timescales. The relevant CYPS Practice Manager or manager of another agency should be informed by the Chair if this does not occur.

35). CYPS Practice Managers must ensure through their supervision of the key worker that Child Protection Plans are fully implemented.

36). No case should be retained on the Duty system for longer than 4 weeks when the social worker is off sick. If there is no immediate prospect of a return to work the case should be re-allocated within a further week.

37). Where parents with mental health difficulties have made threats to harm a child, this information must be shared with and discussed with the mental health services and full risk assessment must be completed.

Devon Partnership NHS Trust – Mental Health Services. (DPT)

38). DPT should develop links between individual sets of case notes for each patient.

39). DPT should comprehensively review its process and policy of clinical risk assessment.

40). DPT will recognise its agency responsibilities in participating in child protection enquiries, including attendance at child protection case conferences, core groups and provision of reports to such meetings. Mental health symptoms in carers especially those symptoms of a volatile nature, should be risk assessed by a consultant psychiatrist. Reports for Child Protection enquiries should be written by or supervised by a Consultant.

41). DPT should put in place a training programme that ensures that all medical staff, nursing staff and Team Leaders participate in the Foundation Child Protection Course.

42). DPT should review their policy of when it is appropriate to share information about patients who are parents with other agencies. This includes issues of consent and when it should be overridden in the interests of the child.

43). DPT should review the roles of Crisis Resolution Teams in order to maximise consistency of care around the time of discharge.

Royal Devon & Exeter Hospital Foundation Trust. (RD&E)

44). All Emergency Department managers will ensure a paediatric liaison form is used, when an adult caring for children presents with self harming behaviour.

45). The policy concerning adults who present with self harm injuries should be reviewed in particular to determine the threshold at which such presentations should lead to a child protection referral.

46). RD&E Midwifery staff to revise the guidelines on actions to be taken when patients disclose past abuse or domestic violence.

47). The Emergency Department training will include adult mental health scenarios in the training to emphasis the duty of care to safeguard children when the adult is the primary patient.

Devon Primary Care Trust – Public Health Nursing Services.

48). Public health nursing managers need to ensure compliance with child protection procedures and the new Devon-wide recording system.

Devon and Cornwall Constabulary.

49). Devon and Cornwall Constabulary to ensure compliance of their officers and staff with existing child protection procedures.

50). The Police need to ensure that all requests for historical information from Child Protection Conferences are processed. If extra resources are needed to achieve this, then this needs to be communicated at the time.

Exeter Drug Project Drug and Alcohol Services. (EDP)

51). EDP should review its management structure to ensure that proper provision is made for consultation with staff about potential risks to children.

52. All cases should be discussed fully at team meeting so that the whole team is aware of the implications of any child protection or mental health issue, are alert to risk indicators and have an opportunity to share best practice.

53). EDP staff to ensure their policy about obtaining patient consent to share information is understood by staff and that staff are aware when they need to pass on child protection issues to other agencies.

54). All EDP team members who completed Child Protection Training more than 2 years previously to undertake a refresher course. All new staff are to undertake training as soon as possible after appointment.

55). EDP should conduct an audit of all cases they are involved in where children are known to be subject to a Child Protection Plan or in Care Proceedings, to ensure they are appropriately involved in the interagency planning process.

South West Ambulance Service.

56). Staff should share any concerns about children with CYPS even when the patient concerned is an adult or another agency seems involved. A clinical note has to be recorded, indicating an assessment of the circumstances of any children known to be involved, as well as the clinical needs of the adult patient. This point will be included in future training and in the relevant internal policies.

NHS Direct.

57). NHS Direct should ensure that Nurse Advisors are provided with further child protection training and management support to increase their ability to effectively screen for and manage child protection concerns.

References.

Working Together to Safeguard Children DfES 2006.

Plymouth, Torbay and Devon Multi Agency Child Protection Procedures 2001.

Children's Needs – Parenting Capacity. The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development. Cleaver, Unell and Aldgate. 1999

Assessment of parenting. Psychiatric and psychological contributions. Ed;- Reader and Lucy. 1998

Assessment in Kinship Care. Ed;- Talbot and Calder 2006

Keeping them in the family: Outcomes for abused and neglected children placed with family and friends through Care Proceedings.
Hunt, Waterhouse and Lutman, Oxford Univ. 2008

Mental Health Policy Implementation Guide Dual Diagnosis Good Practice Guide, Department of Health

National Service framework for Mental Health, Department of Health September 1999

New Ways of Working for Consultant Psychiatrists: Enhancing effective, person centred services through new ways of working in multi-disciplinary and multi-agency contexts. October 2005

New Ways of Working for Everyone: A best practice implementation guide. DoH October 2007.

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