Confidential

CITY & HACKNEY LOCAL SAFEGUARDING CHILDREN BOARD

AN EXECUTIVE SUMMARY OF A SERIOUS CASE REVIEW:

CHILD A & CHILD B

Final draft

11.07.08

Acknowledgements

Members of the City & Hackney Safeguarding Children Board wish to extend their sincere thanks to the father and paternal grandparents of child A and child B who, in spite of their grief, met with the authors of this report and shared their experiences, views and feelings about the services offered to them in the period under review.

A meeting with the children's mother also enabled some limited contribution.

Thanks are due to those professionals in relevant local agencies who committed their time and energy to a rigorous and critical examination of the services provided; thanks are also owed to the consultant who provided the authors of the serious case review report with an independent psychiatric opinion

Terms Requiring an Explanation

'Care Programme Approach'	An holistic multi agency approach to planning service delivery that includes plans for contingencies and crises
EQUIP	Early and Quick Intervention in Psychosis Team -specialises in cases of first presentations of psychosis for patients aged 18-35 resident of City & Hackney, experiencing psychotic symptoms in last 12 months and been known to mental health services for less than 12 months
Named nurse (safeguarding)	Each NHS Trust has a named nurse to promote good professional practice within her/his own organisation and offer advice and expertise for fellow professionals
Senior House Officer	A doctor who has completed her/his pre-registration training and is at the beginning of psychiatric training; work is supervised by 'specialist registrars' and consultants

1 INTRODUCTION

1.1 CIRCUMSTANCES OF CHILDREN'S DEATH

1.1.1 On 27.01.07 police received a 999 call from a Ms C who said she had committed a crime and that her children were not moving. On attending, police found the bodies of child A (a ten year old boy) and child B (a three year old girl), and their mother was arrested on suspicion of their murder.

1.1.2 On 01.08.07 at the Central Criminal Court Ms C was sentenced to indefinite detention under the Mental Health Act 1983 following an earlier admission of manslaughter on the grounds of diminished responsibility.

1.2 ARRANGEMENTS MADE FOR THE SERIOUS CASE REVIEW

1.2.1 The circumstances satisfied one of the criteria for convening a 'serious case review' in the relevant statutory guidance i.e. 'a child has been killed by a parent with a mental illness' and the Commission for Social Care Inspection CSCI (then the relevant regulatory authority) was notified of the decision to initiate such a review.

1.2.2 A 'serious case review sub-group' was convened and agreed the review process. The sub-group, chaired by a person independent of local services comprised representatives of the following agencies:

- Hackney Children & Young People's Services
- East London and the City Mental University Mental Health Trust [since re-named East London NHS Foundation Trust]
- Hackney Learning Trust
- Metropolitan Police Service
- Community and hospital paediatricians
- City & Hackney Teaching Primary Care Trust

1.2.3 CAE (an independent consultancy) was commissioned to collate agencies' individual management reviews and develop an overview for the City and Hackney Safeguarding Children Board (the Safeguarding Board).

1.2.4 An early draft was agreed by the Safeguarding Board's Executive Group on 03.09.07. Completion was however deferred, to allow direct involvement of the family and subsequently the commissioning of an independent psychiatric view of mental health services provided to Ms C.

1.2.5 This summary (and the main report from which it is derived) accepted on behalf of the Safeguarding Board is based upon information and advice provided by those who completed individual management reviews, members of the serious case review sub-group, professionals interviewed during or after those reviews, an independent psychiatrist as well as the children's father, paternal grandparents and mother.

2 SUMMARY OF AGENCY INVOLVEMENT

2.1 FAMILY HISTORY

2.1.1 It is understood that Ms C met Mr D in May 1995, that they started to live together later that year and that Ms C became pregnant and gave birth to her first child A the following year.

2.1.2 During the decade to 2006, agencies' contacts with the family were limited to provision of universal health and education services

2.1.3 Health visiting records indicate that following her birth in 2003 child B lived with her parents and her brother child A.

2.1.4 The parents separated during 2005 and it is understood that by January 2006, the children lived full-time with their father and his parents and (until Ms C refused such contact) visited their mother only at weekends.

2.2 CONCERN ABOUT CHILDREN'S CONTACT WITH MOTHER & HER MENTAL HEALTH

2.2.1 On 24.01.06 Mr D attended Hackney's Children and Young People's Service and expressed his concern that Ms C was not feeding child A or child B and had said she would leave them somewhere. He also recorded that she had said the children did not belong to her and had cut off one side of child B's hair. Mr D was recorded as saying he did not want Ms C to have contact with their children

2.2.2 Mr D was advised to seek legal advice about contact and obtaining parental responsibility for the children (which as an unmarried father he did not possess).

2.2.3 In early February Mr D and his mother reported to Health professionals that Ms C was claiming to be 'God's child' and that she was stating the children were not hers.

2.2.4 Following a referral by her GP, the community mental health team in Hackney made many attempts in March and April to engage with Ms C.

2.2.5 In late April Police received a letter from Ms C indicating her two babies had been still-born and, at birth swapped for two other children.

2.2.6 By late May, a mental health multi disciplinary team meeting concluded that Ms C was unwilling to engage and a decision was made to undertake a formal Mental Health Act assessment to determine the need for involuntary admission to a psychiatric hospital for up to twenty eight days.

2.3 ASSESSMENT OF MS C'S MENTAL HEALTH

2.3.1 In early September 2006 Ms C was admitted to the Hackney Centre for Mental Health and detained under s.2 of the Mental Health Act 1983.

2.3.2 Ten days later Ms C began to acknowledge her children as her own and express a wish to resume having contact with them.

2.3.3 Ms C appealed against her detention but it was upheld by a Mental Health Review Tribunal in late September.

2.3.4 From that time, there was a consistent improvement in Ms C's compliance with medication and her demeanour.

2.3.5 A discharge meeting in early October agreed a comprehensive programme of after care by mental health professionals for Ms C, and a re-establishment of a relationship with her children by Hackney Children & Young People's Service

2.3.6 No concern was expressed about a risk to the physical safety of the children or to any other persons.

2.4 AFTER DISCHARGE FROM HOSPITAL

2.4.1 Ms C was followed up in accordance with the agreed plan, and seen regularly by professionals in the period mid October to the end of January 2007 (by the social worker twice; community mental health staff on nine occasions; GP twice and by the hospital-based doctor three times)

2.4.2 An initial supervised contact session with the children was considered successful by professionals and parents. Implementation of a plan to provide two further such sessions was (partly as a result of the social worker's annual leave) delayed and then replaced, by what became Mr D and Ms C's self-management of contact.

2.4.3 By November it is understood that Ms C was having at least weekly day-time contact with her children.

2.4.4 In early December the social worker (by then returned from annual leave) visited Ms C and advised a slow build up prior to overnight contact.

2.4.5 It is understood that the first overnight contact was two weeks prior to the children's deaths.

2.4.6 The observations of *all* those who saw Ms C following discharge from hospital were consistent in their nature and indicated good recovery from a serious mental illness and positive plans for a future that included those whom by then she acknowledged to be her children.

3 COMMENTARY & LESSONS TO BE LEARNED

3.1 INTRODUCTION

3.1.1 An overall summary of the effectiveness of agencies' involvement with Ms C, Mr D and their children, is that:

- No single judgement or action within any agency triggered or failed to prevent the killing of child A or child B
- The cumulative result of agencies' individual perspectives was that there existed no recognition of a physical risk to the children
- Several examples of sound agency or inter-agency practice were found
- A number of organisational or individual failings have been identified and have informed the recommendations provided in this report

3.1.2 It is the judgement of the serious case review sub-group that *only* if a *physical* risk to the children had been identified by the Mental Health Trust *and* that the subsequent case planning by Hackney Children & Young People's Service had taken account of that risk, *might* the probability of the children being killed have been significantly reduced, or even avoided.

3.1.3 Agencies' assessments and responses must be evaluated with the question in mind 'what was known or could reasonably have been discerned *at the time* to indicate a risk Ms C would harm her children?'

3.1.4 Throughout the period covered by this serious case review, child A and child B were living with their father and paternal grandparents. For much of that time, there was *no* contact between Ms C and her children and professionals were (understandably) confident of the care and protection afforded by Mr D and his parents.

3.1.5 Though these children were born before the law changed to automatically award parental responsibility to a father whose name appears on his child's birth certificate, records indicate that agencies recognised and respected his rights and needs as the actual carer of his children.

3.2 MULTI AGENCY

3.2.1 The recognition of risk to the children arising from Ms C's mental health problems was primarily related to *emotional harm*, resulting from lack of contact with her and from her denial that she was the children's mother. No professionals raised the risk of *physical* harm as a result of the children being implicated in parental delusions.

3.2.2 Following Ms C's discharge from hospital, no evidence has been found in available records of *any* professional or recorded family concerns about Ms C's progress or the welfare of the children.

3.2.3 All professionals who saw Ms C following hospitalisation perceived her to be making a good recovery, a view based on her overall presentation, attendance at appointments and apparent compliance with medication, reported involvement in voluntary work and plans to continue academic study. Most critically, Ms C consistently acknowledged child A and child B as being her biological children, reported that she enjoyed her contact with them and spoke of living with them in the future

3.2.4 There is very limited evidence of any direct professional contact with Mr D after the supervised contact session on 17.10.06. In the absence of any reported concerns, it seems likely the professional network assumed Mr D was comfortable with the contacts he was arranging with Ms C.

3.2.5 There was scope for earlier and improved collaborative multi-agency working including:

- Referrals to Hackney Children & Young People's Service of a parent suffering from delusional thinking involving a child (in accordance with the then relevant London Child Protection procedures)
- Multi-agency involvement in the strategy discussion (in accordance with relevant London Child Protection procedures)
- Holding a multi-agency meeting prior to discharge, to focus on the needs of the children (as opposed to the patient's discharge plan) to provide clarity of the patient's risk assessment, consider if a 'child protection enquiry' was indicated and/or a multi-agency core assessment required and to ensure that the patient's care plan was consistent with the children's welfare

3.2.6 Records indicate professionals gave insufficient thought to their provision of support to Ms C in her request for re-housing (so as to have the children live with her) and did not first communicate with Mr D and try to ensure that any future arrangements would be in the best interests of the children.

3.2.7 The Safeguarding Children Board also need to ensure that the current training programmes and inter-agency protocols for local staff covering the implications of parental mental health issues for child protection, include reference to the:

- Relevance of a parent who has delusional beliefs about her/his or any other child, *regardless* of whether or not the child lives with the mentally ill parent
- Relevant procedure in the latest edition of the 'London Safeguarding Children Procedures'
- Need for multi-agency risk assessments prior to and after hospital discharge, including consideration of the impact of resumption of contact, increased contact and/or resumption of care of children
- Need for consistent involvement by professionals of the other parent / carers of children, especially ensuring they have full information on which to make judgements about contact and raising concerns

3.3 AGENCY SPECIFIC

MENTAL HEALTH TRUST

3.3.1 Members of the Mental Health Trust's responsible team provided a consistent, cohesive service to Ms C, working effectively together, seeking expert advice when needed and communicating well with family members and with Hackney Children & Young People's Service.

3.3.2 There was though, a lack of explicit risk assessment with regard to the:

- Physical risks to the children of Ms C's delusions
- Likely increase in any risk following resumption of contact
- Significance of a reported incident when Ms C answered the door to her relations holding a large knife
- Significance of the incident when Ms C scratched the finger of a member of hospital staff and had to have a kitchen fork removed

3.3.3 There is scope for improving multi-agency working by ensuring that:

- Referrals are made to Hackney Children and Young People's Service in all cases if a parent is suffering from delusional thinking involving a child (in accordance with London Child Protection procedures) whether or not the child currently lives with her/him
- Regardless of whether a child is currently living with, or having contact with a mentally ill parent, any social worker involved with the child is invited to family as well as discharge planning meetings
- Primary care team members are involved in discharge planning meetings, if discharged patients are likely to be responsible or have contact with children
- GPs are provided promptly with details of a patient's discharge date and medication requirements

3.3.4 The assessment completed by hospital staff was based on partial and potentially biased information from family members; it would have been enhanced by seeking objective facts from Hackney Children & Young People's Service about Ms C's birth family and her disrupted and troubled childhood including the circumstances that led to her becoming 'looked after' at the age of fourteen.

3.3.5 There was also found to be scope for improvements in record keeping in terms of clarity of the rationale for decision making, systematic documentation and in legibility.

3.3.6 Though Ms C's 'recovery' in hospital appeared surprisingly rapid, the further expert opinion sought confirmed that research indicates noticeable improvements within four weeks of starting the treatment given and that scientific evidence supports the possibility of a patient making a clinically significant improvement within one to two weeks.

3.3.7 Following discharge, Ms C was followed up very promptly, receiving a home visit within two days and her first outpatients' appointment with a doctor four weeks later. She was subsequently seen regularly at home and at out-patient appointments.

3.3.8 The consensus that Ms C's mental health had improved from that prior to her hospital admission inevitably reduced the previous significant concerns about the emotional harm her children might be experiencing.

3.3.9 Following discharge from hospital, staff were reliant on Ms C's self reporting, and assessment of her presentation, to ascertain if she was taking her prescribed medication.

3.3.10 Blood tests taken after Ms C's arrest showed no trace of prescribed medication. To the Forensic Science Service toxicologist, this indicated Ms C had not been taking the medication therapeutically for 'at least a few', and 'perhaps as many as ten days earlier'.

3.3.11 It thus remains uncertain whether Ms C misled various professionals she saw in the ten days prior to the children's deaths about her compliance with treatment.

HACKNEY CHILDREN AND YOUNG PEOPLE'S SERVICE

3.3.12 Interviews with Mr D and his parents indicated a significant difference between their expectations about the role of Hackney Children and Young People's Service and that implied by the agency's formal records:

- The paternal family indicated that their understanding of parental responsibility and comments made by the social worker, meant that they had no choice except to facilitate the children's contact with their mother
- The position implied by records and confirmed by the social worker implied a very limited role for the department in what had become [by default] the family's self-managed rehabilitation programme

3.3.13 There is a need for Hackney Children and Young People's Service to review reception and duty structures and systems to ensure that:

- The contact / referral process does not introduce any loss or dilution of the information presented
- Referrals relating to welfare concerns about a child should always be subject to a response that establishes sufficient information to establish the nature of concerns and determine any risk to the child
- Messages taken in the absence of a social worker should be monitored and relevant responses provided and recorded within the child's record

3.3.14 There was a significant delay in the commencement and completion of the initial assessment by the social worker and a further delay prior to its authorisation by a manager.

3.3.15 Mr D was appropriately advised in January 2006 to obtain legal advice and again in July 2006 of the need to obtain parental responsibility so as to ensure his children's stability and security. It was pointed out that whilst Ms C was at that point unable to care for her children, the likely duration of her mental health problems was not known.

3.3.16 The plan for reintroducing Ms C to her children, involving a therapist and supervised contact, was well considered and appropriate, and considered to be successful by the professionals involved as well as Mr D and Ms C.

3.3.17 Following Ms C's discharge from hospital, Hackney Children & Young People's Service neither possessed nor was provided with, evidence that would have justified an application for or obtaining of, any form of protective order.

3.3.18 There was regrettably, poor communication with the parents and other involved professionals about the aborted plans for further supervised contact.

3.3.19 Following Ms C's reports of further successful contact visits and her plan to have the children live with her, further efforts should have been made to contact Mr D and assess the situation before deciding whether or not to support Ms C's request for re-housing and close the case.

3.3.20 There is scope for improved management systems to ensure that:

- Initial assessments are undertaken within timescales and with the degree of urgency appropriate to the case
- Managers authorise completed assessments without delay
- Managers track the progress on cases and record decisions with regard to components of assessments / support
- Cover arrangements are made on social workers' cases

THE LEARNING TRUST

3.3.21 The quality and adequacy of records varied within the three establishments involved in this case:

- The Trust was unable to locate any school records for child A for the nineteen months he attended his first school
- Child B's playgroup had a record of the January 2007 telephone check made with them by Hackney Children & Young People's Service , but not of the check made in August 2006
- Child A's last school did not have a record of either telephone check made with them by Hackney Children & Young People's Service

GP & HEALTH VISITING SERVICE

3.3.22 The first of the two GPs involved is to be commended for her home visit following reported concerns and consequent full referral, which included relevant details of Ms C's history, including the fact she had been 'looked after' from the age of fourteen.

3.3.23 Though unrelated to the tragic killing of these children, consideration of child B's early health records enabled the serious case review to identify scope for improved practice with respect to the management of failure to thrive in the primary care, and with specialist teams.

POLICE

3.3.24 There is scope for improving liaison arrangements when, in non-emergencies, police support is required for the completion of a formal mental health assessment and hospitalisation of a disturbed patient.

3.4 REVIEW PROCESS

3.4.1 Completion of this serious case review suggests that there is scope for improving efficiency and for negotiating and developing a common approach to the currently separate processes required of Health Trusts, of 'Serious Untoward Incidents (SUIs) and their contribution to 'Serious Case Reviews as set out in *Working Together to Safeguard Children*, 2006.

4 RECOMMENDATIONS

4.1 INTRODUCTION

4.1.1 Recommendations have been derived from, but are not limited to those arising from individual management reviews. They have been divided into those of relevance to more than one of the agencies involved, those which are agency-specific and those which relate the case review process itself.

4.1.2 The majority were agreed prior to the agreed postponement of the serious case review and though the independent psychiatric report subsequently received did not necessitate significant alterations of pre-existing recommendations, it *did* prompt development of three additional ones (4.3.1, 4.3.10, and 4.3.12).

4.1.3 All the recommendations have been accepted and have been already, or are currently being implemented.

4.2 MULTI AGENCY

4.2.1 City and Hackney's Safeguarding Children Board should communicate formally with London's Safeguarding Children Board and propose further clarification in future procedures about parental delusional thinking involving a child; issues to be specifically addressed to include the:

- Application of child protection procedures with regard to parental delusions that involve the child, even if the child is not currently living with the parent with mental health problems
- Need for referrals to be made to Children's Social Care *whenever* parental delusional thinking involves the child (consistent with para. 4.6.37 in ed.2 London Child Protection procedures) and use of consultation processes in agencies and with Children's Social Care if professionals are uncertain if observed behaviour meets this criterion
- Use of multi-agency strategy discussions for all such referrals, to consider if a s.47 enquiries are warranted and plan further assessments and/or support required
- Involvement of mental health staff in all such strategy discussions to provide information, if involved, and consultation in all cases
- Holding of a recorded multi-agency meeting prior to the patient's hospital discharge, involving responsible consultant psychiatrist, Mental Health Trust named nurse, community mental health staff, Children's Social Care, GP and other relevant professionals / agencies

- Focusing of such a multi-agency meeting on the needs of the child (as opposed to the discharge meeting's focus on the patient), which will involve consideration of an explicit risk assessment of the patient, any further assessments required e.g. s.47 enquiries, multi agency core or specialist assessments, and ensuring that care plans made for the patient are consistent with the welfare of the child
- Involvement of the other parent / carers of a patient's children in discharge planning and risk assessment, so as to ensure assessment and planning is based on full information and those responsible for a child are fully aware of assessed risks[1]

4.2.2 The Safeguarding Board should review (and if necessary improve) member agencies' single or multi-agency training on the relevance of parental mental health to child protection, ensuring that:

- It reflects current structures and sources of expertise such as 'named professionals' in relevant agencies
- Issues associated with parents who are not currently caring for their child are recognised
- Implications for children of any fixed delusional beliefs of a parent are addressed (including the need to seek advice from internal sources of expertise and refer to the Children & Young People's Service in accordance with London Child Protection procedures para. 4.6.37 edition 2)

4.2.3 City and Hackney's Safeguarding Children Board should review its mental health protocol so as to ensure that:

- Joint working agreements reflect the need for multi-agency involvement (as per para. 4.2.1), even for children not currently living with the parent with mental health problems
- Staff are aware of relevant protocols
- Hackney Children & Young People's Service and primary care staff are involved in care planning and discharge arrangements through invitation to meetings and provision of written information
- GPs are provided with timely information regarding patients' discharge date and medication needs
- Child protection thresholds are understood by staff in all agencies

4.2.4 The Safeguarding Children Board should develop a simple audit tool for adaptation / application across member agencies so that each can regularly check the quality of record keeping, in particular the extent to which staff are recording service user names correctly and consistently.

[1] Concern has been expressed by Mr D that he was not informed about what he considers to be relevant details of physical threats allegedly made in July 2006 by Ms C to members of her extended family. The Mental Health Trust has latterly confirmed that (in accordance with its confidentiality policy) some details were not provided to Mr D or the social worker. This justifies consideration by the LSCB (by 30.09.08) of current information sharing protocols and practice regarding the balance between patient confidentiality and justifiable disclosure in the wider public interest (including protection of children).

4.3 AGENCY- SPECIFIC

EAST LONDON & THE CITY MENTAL HEALTH TRUST

4.3.1 The Trust should ensure via briefings and procedures and reinforce through training programmes that relevant staff are made aware of the need to undertake explicit risk assessments for patients suffering with / who have suffered from delusional beliefs involving child/ren and such assessments should:

- Specifically cover the risk to the children
- Be undertaken in liaison with professionals from relevant other agencies
- Involve family members, in particular other parents / other carers of those child/ren

4.3.2 The Trust should, via briefings and procedures ensure that all staff are informed:

- Of the need to base assessments on accurate and objective information of the patient's history
- That if a patient was looked after at any stage in her/his childhood, information should be sought from Hackney Children & Young People's Service and that this should be taken into account in the consideration of the level of involvement of the family in care planning arrangements
- That support should not be provided for a patient to resume care of her/his child unless there is a process in place to ensure that future arrangements would be in the interests of the children

4.3.3 The Trust should integrate community outpatient clinics with community mental health teams into one database, moving to co-location, with shared responsibilities for the case load of the entire multi-disciplinary team; the Trust should make provisions regarding availability of medical staff in community mental health teams, ensuring each has access to a senior doctor (associate specialist or specialist registrar) working under the supervision of the consultant.

4.3.4 The clinical director should review the role and supervision of senior house officers and their consultant supervisors in follow up and outpatient appointments.

4.3.5 The Trust should review how to assist clinicians in systematically considering (when indicated) a range of measures to ensure compliance with medication including monitoring through community support workers and district nurses, depot medication and obtaining blood serum levels if and when possible**.**

4.3.6 A review should be undertaken of note keeping standards to include cross referencing between 'progress notes' and other documentation on file relevant to the progress notes and development of guidelines and training tools enabling clinicians to compose narrative case summaries and clinical formulation.

4.3.7 Following restructuring of the community mental health teams, the approved social work service should be reviewed to see how it best fits with the restructured community mental health teams (consideration should be given to putting systems in place that allow for Mental Health Act assessments to be allocated and managed locally within the teams whilst maintaining an emergency borough-wide rota).

4.3.8 The Trust should introduce a procedural expectation that adult mental health services consider risks to, and impact of parental mental illness on, non-resident children of patients and seek advice and involvement from 'parental mental health workers' and the 'safeguarding children team', who should continue to be informed about key events until a joint decision is made that safeguarding children or parental mental health issues are being managed appropriately without their support.

4.3.9 The Trust should require each team and ward in adult mental health services to audit the proportion of staff who have attended the established 'safeguarding children' training levels 1 and 2, and ensure that staff attend mandatory training.

4.3.10 The Trust should review its '*Safeguarding & Promoting the Welfare of Children*' policy to ensure it covers lessons learned from this serious case review with respect to physical risks to children arising from parental delusions.

HACKNEY CHILDREN & YOUNG PEOPLE'S SERVICE

4.3.11 The Access and Assessment Service should review:

- Decision making at point of first contact, in particular when the response to an incoming request is 'no further action'
- Arrangements for tracking assigned casework such as the formulation of formal assessments
- Current practice with respect to the inclusion of mental health staff in strategy discussions concerning parents with mental health difficulties
- Arrangements for covering staff and management absences

4.3.12 Procedures should be amended, and briefing sessions and training reinforce a requirement that any assessment of children's contact with a parent who has experienced delusions about her /his child/ren, should recognise the need for a plan to monitor the quality of the relationship over time (this may involve further direct work with the family or explicit arrangements with other professionals and family members)

4.3.13 Social workers should not provide written support to parents for re-housing (to facilitate children going to or returning to live with them), without a prior assessment process that involves communication with current carers and ensuring that future arrangements would be in the interests of the children

THE LEARNING TRUST

4.3.14 The Trust should review record keeping practice within schools and nurseries to ensure that it meets the requirements of safeguarding policies and procedures.

GP & HEALTH VISITING SERVICE

4.3.15 When discharged patients are likely to be responsible for unsupervised - care of young children, relevant 'primary care team' members should respond to and whenever practicable, participate in risk assessment and discharge planning meetings convened by the Mental Health Trust or Hackney Children & Young People's Service.

4.3.16 Training programmes and supervision procedures should reinforce:

- Best practice in the management of failure to thrive
- Recording of health professional liaison meetings and their outcomes
- The need to follow up if primary care team members become aware of a child's non attendance at a specialist referral clinic
- The requirement to notify change of a child's home address to the PCT Child Health data base

POLICE

4.3.17 The police should ensure that resources can be made available to consistently provide support for completion of formal mental health assessments and hospitalisation of disturbed patients.

4.4 RELEVANT TO REVIEW PROCESS / NATIONAL APPLICATION

4.4.1 For those cases that require both a 'serious untoward incident review' and a 'serious case review', the Safeguarding Children Board should develop in consultation with the Strategic Health Authority and OfSTED a complementary approach that will:

- Clarify the respective purposes
- Maximise the extent to which the information gathered may be applied to both processes
- Optimise deployment of the most relevant personnel
- Make explicit the methodology to be followed, time frame to be satisfied and the necessary support services