Executive Summary

Serious Case Review in accordance with the guidelines laid out in Working Together to Safeguard Children 2006 and Working Together to Safeguard Children, Chapter 8, 2009

Child C
Age 3 months (at date of incident)

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1 Circumstances Leading to a Review

1.1.1 Child C, the daughter of Mr N and Ms T was, at the age of three months, admitted to Hospital 4 by ambulance with her parents, who stated she had suffered fits. On examination Child C had bruising and abrasions above and around her right eye.

1.1.2 Subsequent medical examination confirmed, in addition to the above injuries, Child C had fractures to the ribs on both sides, hand, skull, left parietal bone and knee cap and retinal haemorrhages behind the eyes.

1.1.3 Ms T's explanation was she had dropped Child C. The explanation did not fit the injury pattern and an interim care order was obtained and Child C subsequently placed with foster carers. A criminal investigation is ongoing.

1.1.4 Both parents had histories of depression. Mr N suffered a serious head injury some years previously. This affected his behaviour to the extent he had come to the attention of the police on grounds of risk to other persons on two occasions. The parents had been in a relationship for about a year prior to Child C's birth and were living together.

1.1.5 At the time of the incident, a core assessment by children's social care (CSC) was underway, as a culmination of a number of concerns including domestic abuse, Ms T's history of self harm, parental capacity and previous referrals by health visitors to the common assessment framework (CAF) team and CSC. Adult and community services (ACS) were coordinating support for Mr N and a voluntary agency (Volorg 1) was also supporting and assessing the family.

2 Review Process

2.1 Criteria for meeting Chapter 8 requirements

2.1.1 The Bromley Safeguarding Children Board (BSCB) agreed to conduct a serious case review under the conditions outlined in chapter 8, paragraph 8.6 of Working Together 2006. During the course of the review a revised chapter 8 was published. The review took account of the revised guidance.

2.1.2 The BSCB identified the following specific issues for consideration:

1. To what extent did universal services identify the vulnerability factors for this child?
   i. Was there sufficient concern during the pregnancy that would/should have warranted support from early intervention services?
   ii. Given the known co-existing issues relating to the parents, should an unborn risk assessment have been undertaken at an earlier stage in the pregnancy?

2. What was the quality of assessments of parenting capacity? Did they include both parents?

3. Were the London Child Protection Procedures adhered to with regard to safeguarding children, in particular, domestic violence, parental mental health problems and alcohol misuse? If not, what decisions were made and what factors led to procedures not being followed?

4. How effective was the referral process including referrals to social care and the social care response?

5. Given the known and documented information regarding the parents, were the assessments and decisions made thorough or wide enough to make an informed decision?

6. Were Adult Services, CAF Team, Health or other professionals consulted as part of any information gathering or assessment?

7. What training and supervision had the workers involved in the case received in relation to safeguarding children in particular, the impact of domestic violence, parental mental health problems and alcohol misuse on a parent's capacity to effectively care for a young baby?

8. Have similar issues, as identified in this case, arisen in a previous serious case review?

2.1.3 Individual management reviews and chronologies on which the overview report is based were provided by the following agencies:

- Children's Social Care (CSC) who were conducting an initial assessment
- Adult and Community Services (ACS) who were coordinating support for Mr N
- Hospital 1 NHS Trust who provided ante natal and post natal midwifery services
- Hospital 2 NHS Trust who provided community midwifery services
- The local PCT who provided GP services
- The local PCT Community Provider Unit who provided health visiting services
- The ambulance service regarding the injury to Child C
- Metropolitan Police Service who responded to domestic abuse incidents
- A voluntary agency (Volorg1) who commenced an assessment of familial support needs.

2.1.4 A health overview report was provided as required by the Strategic Health Authority, London, to ensure a view of how effectively NHS services worked together.

2.1.5 Additional background information was provided by agencies with lesser involvement.

2.2 Serious case review panel (SCRP) membership and process

2.2.1 The SCRP comprised the following members. None directly line managed staff involved in the review.

- Assistant Director, CSC
- Designated Nurse, Primary Care Trust (subsequently replaced by the Interim Designated Nurse Child Protection due to designated nurse leaving the PCT's employment)
- Consultant Public Health, Primary Care Trust
- Designated Doctor, Safeguarding Children,
- Lead Officer Safeguarding, Education
- Police Serious Crime Review Group, Specialist Case Review Officer.
- Interim Head of Service, ACS.

2.2.2 The panel was supported by the BSCB Development Officer, and the BSCB Administrator/Coordinator.

2.2.3 The panel was chaired by Jenny Dibsdall, the independent chair of the BSCB. The overview report was written by Bob Cook, an independent consultant.

3 Conclusions and Lessons Learned

3.1 Introduction

3.1.1 The review identified three broad themes:

i. The quality of risk assessment
ii. The relationship between adults' and children's services
iii. The experience and confidence of staff coupled with the level of demand.

3.2 The quality of risk assessment

3.2.1 The 2005-7 biennial safeguarding review discussed the importance of understanding cases from an interactive risk perspective, identifying three themes (child factors, family and environmental factors and practice/professional/agency factors).[1] The handling of the three themes, that combined had the potential to increase risk are summarised in the following two paragraphs.

3.2.2 Family/environment and child related factors creating risk to Child C that were either not picked up at all or were not adequately considered included:

i. Both parents receiving treatment for depression, during Ms T's pregnancy, from the GP practice they both attended
ii. Reports that Ms T had self harmed
iii. Two police MERLIN[2] notifications during the period of the review and midwives and health visitors observing an unstable parental relationship
iv. Ms T's expressed distress and frustration to health visitors and midwives about Child C's frequent crying
iv. Mr N's serious head injury that had impacted on his cognitive functioning and had in some situations led to him presenting a risk to others
v. Health visitors' and midwives' identification of poor parental coping strategies and a somewhat immature attitude to the care of Child C.

3.2.3 Practice, professional and agency failures of process that either hid some of the above concerns or led to them not receiving adequate assessment included:

i. Police and ACS not identifying or sharing information with CSC about the alleged risks to others from Mr N
ii. GP not sharing information with ante natal services
iii. CSC's poor analysis of the significance of the health visitor's information leading to an initial decision not to assess the risks identified in her referral
iv. The health visitor's ruling out of child protection concerns in her referral to CSC
v. CSC not being fully aware of and/or utilising the pan London domestic abuse procedures and risk assessment matrix
vi. Poor decision making in CSC in response to the health visitor's referral resulting in an inappropriate referral to a voluntary agency instead of CSC assessment
vii. Subsequent failure by CSC to pass information to and share information with the voluntary agency

[1] Understanding Serious Case Reviews and their Impact: A Biennial Analysis of Serious Case Reviews 2005-07 Marian Brandon, Sue Bailey, Pippa Belderson, Ruth Gardner, Peter Sidebotham, Jane Dodsworth, Catherine Warren and Jane Black (2009) pp 38-9

[2] MERLIN is the police system for recording child protection information. MERLIN generates an electronic report that is sent to social care and health agencies

viii. Inexperienced and highly pressured staff in CSC leading to allocation to a newly qualified worker and over-stressed managers acting down to cover vacancies
ix. Lack of timeliness in progressing assessments
x. Failure to assess and mobilise potential sources of support in the extended family
xi. Lack of any formal planning processes or meetings (strategy, child protection or team around the child) .

3.2.4 Although many of the risks in 3.2.2 were identified in the health visitor's referral, CSC did not agree to undertake an assessment for a further month and this was precipitated by a further police MERLIN notification. The assessment criteria set by the CSC manager was *"to look at the couple's understanding of the impact of domestic violence on children and to explore how they would address the difficulties in their relationship and resolve future disagreements."*

3.2.5 This was very much a focus based on supporting the parents and discounted most of the known concerns about risk identified both by the health visitor and set out in 3.2.2 above. Identification and evaluation of the risks would have been facilitated by addressing the points in the failures of process identified in 3.2.3.

3.2.6 The CSC initial assessment provided little information or analysis and the core assessment, as well as being seriously deficient in scope, was never progressed. Thus no conclusions were reached that might have led to a protection plan and the possibility of a different outcome for Child C.

3.2.7 The key lesson is the importance of practitioners and managers, not just in social care, but in all constituent LSCB agencies having a good understanding of risk assessment, including both vulnerability and protective factors, and of assessment tools. This requires a combination of better supervision, demand management, skill development, assessment tools and appropriate use of strategy meetings.

3.2.8 The risk matrix in the pan London domestic abuse procedures to assess the impact of domestic abuse is a good example of a risk assessment tool. While it specifically assesses the impact of domestic abuse on child safety, it includes the impact of both other risk and protective factors. Not all staff had received full training in use of the procedures and matrix. Had the matrix been properly understood or used it could have identified the concerns in this case, especially if coupled with good information sharing and discussion within and between agencies.

3.2.9 Positively the BSCB has undertaken a recent audit of the effectiveness of the application of domestic abuse procedures and the taking forward of the recommendations from this audit should additionally be informed by the findings of this SCR.

3.3 Adults and children's services

3.3.1 Many of the services with responsibilities for Child C's needs were also providing specific services to the parents, the GP in relation to parental mental health and the police in relation to domestic abuse. In particular, significant services for Mr N were also being provided by and co-ordinated through ACS.

3.3.2 As noted in the previous section, information known by police and ACS about Mr N's alleged history of risk to others was not identified or shared. The importance of facilitating better liaison between adults' and children's services, including review of electronic recording systems has been identified.

3.3.3 The GP failed to pass to ante natal services that Ms T was recovering current mental health treatment and did not identify that Mr N, also receiving GP mental health treatment, was the father of Child C. The importance of understanding the significance of fathers has been identified as a key theme in the 2005-7 biennial review.[3]

3.3.4 Recommendation 21 of Lord Laming's report states "*The National Safeguarding Delivery Unit (NSDU) should urgently develop guidance on referral and assessment systems for children affected by domestic violence, adult mental health problems, and drugs and alcohol misuse using current best practice. This should be shared with local authorities, health and police with an expectation that the assessment of risk and level of support given to such children will improve quickly and significantly in every Children's Trust."*

3.3.5 This has been identified as project 5 in the NSDU's interim report[4] and is of obvious relevance to the identified concerns about prior risk assessment and poor liaison between adults' and children's services in this case. This information, including also assessment of the impact of parental head injury on cognitive functioning and parenting capacity in the safeguarding of children may be helpful to the NSDU in developing their guidance.

3.3.6 The importance of police identification and sharing of information about previous violent behaviour, whether or not related to domestic abuse when passing MERLIN information may require a tightening of the pan London domestic abuse procedures.

3.4 Staff support and levels of demand

3.4.1 This review has identified some significant concerns about workloads and skill levels. Vacancies in ante natal support for mothers with mental health needs have been identified and addressed by the relevant Trust. It is CSC where demand has had most impact with significant increases in referrals and assessments during the 2008-09 year. As a consequence this case was given to a recently qualified social worker who, despite being newly appointed, was already carrying a high caseload. This worker felt she had little regular supervision or induction. However this increase in demand would obviously also at some point impact on all agencies.

3.4.2 External inspections identified a high turnover of CSC managers and use of locums resulting in reduced supervision and lack of monitoring of staff development needs, a theme in this case where at one point a senior manager was acting down, in addition to their regular duties, to cover the duty service.

3.4.3 Lack of experience, high demand and poor supervision had an obvious impact on the quality of assessment in this case. The social worker had concerns the case was not being assessed under s47 criteria but did not feel sufficiently confident to voice this.

3.4.4 In contrast, the health visitor did challenge the CSC manager over the decision not to undertake an assessment and was able to make positive use of sessions with the named nurse to reflect on different options for taking the case forward.

3.4.5 Lord Laming noted "*concern that the tradition of deliberate, reflective social work practice is being put in danger because of an overemphasis on process and targets, resulting in a loss of confidence amongst social workers. ……..Regular, high-quality, organised supervision is critical, as are routine opportunities for peer-learning and discussion….. Supervision should be open and supportive, focusing on the quality of decisions, good risk analysis, and improving outcomes for children rather than meeting*

[3] Brandon et al 2009 pp 51-3
[4] NSDU Interim Progress Report & Work Programme 2009-2010 p 13

targets".

3.4.6 The final report of the Social Work Task Force[5] (SWTF) has recommended a new supported and assessed first year in employment, binding standards for the resourcing and management of front line social work and a dedicated programme of training and support for managers of frontline social workers, all points that will address the findings of this review in relation to staffing and levels of demand.

3.4.7 The SWTF also recommended children's services departments should hold frank and open discussions with frontline practitioners and managers about the reality of practice on the frontline, the burdens practitioners are carrying, and how they can improve services. It is essential the taking forward of this in the Bromley LSCB area utilises the findings of this review.

3.5 Other findings

3.5.1 After Child C's admission to hospital, there was a delay in the police being informed as the out of hours social work team did not pass this information to the police, who were informed by the day team. While this had no adverse consequences in this case, in other circumstances, e.g. had the parents tried to remove Child C from the hospital, police protection might have been necessary.

3.6 In conclusion

3.6.1 This case has identified serious deficiencies in the assessment and management of identified risks, compounded by levels of demand upon front line staff especially in CSC. As the significance of and interplay between these risk factors, identified in 3.2.2 and 3.2.3, was not analysed at the time it is not possible to definitively establish whether a support or protection plan could have been put in place that would have prevented the circumstances of Child C's injuries.

3.6.2 Certainly, there can be no guarantee that the injuries to Child C would have been identified earlier, noting clinical advice in the Royal College of Paediatrics and Child Health *Child Protection Companion,* that identification of fractures is often not possible on a purely visual medical examination.

3.6.3 What can be said is that, had the specific factors been fully and appropriately risk assessed, there is a strong likelihood that an assessment under s47 would have taken place, a child protection conference would have been held and either a child protection plan or a very robust child in need plan would have been in place to co-ordinate adults' and children's service provision and extended family support in managing better the risks to Child C. This could have resulted in a different outcome.

4 Recommendations

4.1 Recommendations for the BSCB

1. The BSCB should ensure that the effectiveness of the current multi-agency risk assessment training is reviewed to ensure all relevant practitioners have undertaken it and it fully covers the following specific points identified in this review:
   i. Assessment of fathers
   ii. How information held on existing files is considered
   iii. Impact of parental vulnerability on the child including parental mental health, learning difficulty or disability and cognitive impairment following injury

[5] Building a safe, confident future: The final report of the Social Work Task Force: November 2009

iv. Assessment of domestic abuse including linkage with the recommendations of the recent BSCB audit
v. How immediate and extended family members may be involved
vi. Ensuring the full contributions of all involved agencies
vii. The effective use of strategy and planning meetings.

2. The BSCB should ensure the Barnardo's domestic abuse training, or an equivalent of similar quality, is available to all front line staff on a regular basis and that its effectiveness to date is reviewed.

3. The Chair of the BSCB should write to the MPS and the London Safeguarding Children Board requesting consideration be given to the pan London domestic abuse procedures requiring the police to include information about any previous violent behaviour, whether or not related to domestic abuse, when sending MERLIN notifications.

4. The Chair of the BSCB should write to the National Safeguarding Delivery Unit summarising the issues in this case about domestic abuse and parental mental health including the impact of parental head injury on cognitive functioning and parental capacity, requesting the NSDU use this as they see fit in developing their guidance on domestic abuse, parental mental health and substance abuse

5. The BSCB should satisfy itself that all front line practitioners involved in child protection, however limited their experience, should feel able to openly discuss concerns, including the judgement of more senior colleagues and have these taken seriously.

6. The BSCB should satisfy itself all constituent agencies are aware of the need to advise the police Child Abuse Investigation Command (CAIC) out of hours service in a timely manner of all incidents when they are informed a child has been admitted to hospital out of hours and serious abuse is suspected.

7. Progress on implementation of the following points from previous SCRs should be reviewed in the light of the findings of this SCR
   i. Staff recruitment
   ii. Rigorous and challenging supervision
   iii. More effective working between children's social care and mental health services
   iv. Communication between health visitor and GP
   v. Lack of a comprehensive social history in GP antenatal referrals.

8. The BSCB should require the Practice Standards Board (with representation from adults services, community mental health services and children's services) to establish what policy, practice and supervisory changes are necessary to ensure:
   i. Adults services identify whether service users who are parents or prospective parents might need support in caring for or present risks to a child
   ii. Children's services identify whether parents are known to adults' services or might require an assessment for adult services
   iii. How information sharing and understanding of thresholds could be improved between adults' and children's services
   iv. What changes may be needed to electronic recording systems to facilitate this.

9. The BSCB should ensure there are appropriate arrangements for supporting staff whose practice is scrutinised in a serious case review

4.2 Recommendations for individual agencies

10. **The CSC management team** should, in the light of the findings of this SCR and the recommendations in the Social Work Task Force report, identify and implement practical actions to reduce the impact of demand and workload on frontline staff and managers.

11. **The CSC management team** should review the effectiveness of arrangements to ensure commissioned services only work within their agreed remit.

4.3 Learning from the SCR and implementation of recommendations

12. The BSCB should ensure all agencies implement the recommendations made in their Individual Management Reviews and provide an update on their implementation to the BSCB as required.

13. The BSCB should ensure all agencies feed back learning from this review to staff members who were directly involved and learning is effectively disseminated throughout all levels of their organisation.

Bob Cook
Children's Services Consultant,
22/03/10

5 Appendix: Recommendations from IMRs

CSC

1. Senior managers in the CYP department should urgently review the staffing levels and referral rates of the Penge duty and referral team and across all front line child protection teams to ascertain whether the work load is of a manageable level.

2. Senior managers within the Children's social care division should identify the extent to which managers are 'acting down' in front line teams and whether this constitutes safe practice.

3. Children's social care should review their use of the supplementary procedures in relation to domestic violence to determine whether there should be greater clarity in Bromley's procedures of the situations and circumstances that should lead to section 47 investigations in respect of unborn and under 1 year olds.

4. The impact of the Barnardo's training package on practice in Bromley should be reviewed to analyse any shortcomings in the process and identity further training needs for staff in social care.

5. Children's social care should review their practice and protocols around the management of newly qualified staff and ensure there are clear guidelines around caseloads.

6. Children's social care should review their induction process for new staff and ensure all managers are aware of the requirements of new staff.

7. Social workers and their managers should be reminded of the importance of recording their contacts with families and professionals contemporaneously and the significance this plays in ensuring appropriate assessments of children.

8. Senior managers across key agencies in Bromley should consider whether a joint screening of referrals (particularly between police, social care and PCT) should be considered.

ACS

1. All care managers who work with younger adults should attend the Child Safeguarding training recently put in place.

2. Review the external provider training for Domestic Violence, for all care managers working with younger adults and their families. This training should be mandatory and in place by June 2010

3. Clear guidance on the processes staff should follow, in relation to the safeguarding of children, needs to be implemented by senior management. A joint protocol is necessary and this issue will be referred to the Practice Standards Board by June 2010. This Board will agree joint training, policy and procedures so that staff are clear of their responsibilities. This Board is attended by ACS and CSC; CSC should make sure they attend regularly.

4. All referrals to the PDSI team should follow the guidelines and be in writing.

5. Consideration should be given to look at how allegations regarding risks to others can best be added to the current classification section on the borough's computer system.

MPS

In view of all the changes that have taken place within the MPS to support the Every Child Matter's Agenda, and actions already taken, no recommendations are made.

Volorg 1

Within agency

1. Supervision Package – to re-train staff in systems that are already in place and monitor progress.

2. Volorg 1's ROUTES (Recording, Observing, Unique Assessment, Transition, Evidencing and Safeguarding) framework, (which is a framework that assists Volorg 1's projects to develop consistency of evidence based practice) includes :-
   - Referral
   - Individual Support Plans
   - Progressing Route
   - Management and Support Structure
   - Monitoring and Evaluation

Inter-agency issues

1. Ensure referrals are relevant to service provision.

2. Improved sharing of information to enable all agencies to meet the needs of clients

Hospital 1

1. Hospital 1 should revisit and audit evidence from the previous SCR.

2. There needs to be a formal procedure to identify the correct team to provide post natal care to mothers and babies on discharge from the hospital.

3. There needs to be a safe procedure to formally record and transfer the request for post natal follow up safely from site to site.

4. Lessons learned from this SCR are to be taken forward in the future planning of the Trust safeguarding training.

5. The two identified midwives who are due their training update should complete theses sessions.

Hospital 2

1. Midwives should be reminded in training to make independent referrals to Children's Social Care when they identify concerns.

2. There needs to be a formal procedure to identify the correct team to provide post - natal care to mothers and babies on discharge from hospital.

3. There needs to be a safe procedure to formally record and transfer the request for post - natal follow up safely from site to site.

4. Trust staff should make every opportunity to retrieve post natal care plans.

5. There needs to be a Trust policy for staff to follow in order to retrieve post natal care plans where there are difficulties.

PCT Health visitors

1. The use of the Health Visitor Family Health Needs Assessment (a tool for identifying risk factors which can impact on the parent's ability to parent) should be used universally by the HV Team on all families. This has been updated to reflect the Every Child Matters 5 outcomes. It was launched on 25th November at the district wide Health Visitors Meeting. It is envisaged that it will be used from January 1st 2010 as a routine tool to assess difficulties within a family.

2. Health visitor record keeping: it is recommended that all entries in Progress Notes on RIO, our computer based records, are written contemporaneously, starting with a date, time, location and reason for visit and validated at time of writing. Record keeping training has been delivered to 70 Health Visitors since September and a further session is planned in January.

3. For clients with additional needs, it is recommended that alerts are used on RIO to highlight families in need of support or where there are safeguarding concerns. HV also use the Monthly Team Planner on RIO and staffs need to check their targeted monthly team planners weekly to ensure there is timely follow up of vulnerable families and children. An audit was completed recently on Record Keeping by reviewing the paper and electronic records to identify to what extent procedures are being followed to identify children and families who have been subject to the child protection process following which further training was undertaken. It is recommended that a re-audit is done in 2010 to ensure practice had improved.

4. The service should work in conjunction with other agencies to look at the provision of early support for vulnerable families which should include access to parenting support in local Children Centres.

5. All members of the HV team need to ensure they keep their Safeguarding training updated, including CAF, Risk Assessment Training, Domestic Violence, Parental Mental Health and Drug + Alcohol Misuse.

PCT GP

1. GPs to remember to take a social history to include details of any problems fathers might be having in antenatal referrals.
   a ACTION – antenatal referral templates to be developed to include this specifically. Their usage could be audited.
   b ACTION- GPs to be reminded via GP newsletter.

2. GPs to remember to ask about mental wellbeing at first contact antenatally and postnatally.
   a ACTION – circulate the NICE antenatal and postnatal mental health guidelines link.
   b ACTION – antenatal referral templates to be developed to include this specifically. Their usage could be audited.

3. Further training for health care professionals on domestic violence.
   a ACTION – circulate the BSCB domestic violence guidelines again.

4. Health professionals to remember that men are parents too and their mental health and cognitive ability can affect parenting

a ACTION – put this recommendation in GP newsletter.
b ACTION- a reminder of the risk factors relevant to safeguarding children to be included at the next academic half day.

LAS

The Trust has not identified any learning from its involvement in this tragic case but is willing to take on board any issues or recommendations the SCR may identify

Health Overview

1. The PCT commissioners and CPU must contribute to a discussion with social care and police regarding screening of MERLINs to identify how a more effective joint system can be set up.

2. Health trusts must ensure that there are procedures for checking addresses for children being discharged from hospital. Where health trusts are providing services across the three boroughs there should be robust links between the teams to ensure consistency of work and effective sharing of records if a different team becomes involved.

3. All health trusts must ensure that the CAF process is embedded within the safeguarding procedures. There should be a clear recognition of which staff are expected to complete CAFs and these members of staff must attend the CAF training.

4. Formal processes for information sharing regarding children about whom there are concerns between GPs, midwives and the CPU health visiting and school nursing service must be established. These processes should provide clear evidence of what information sharing has taken place and any assessment or actions resulting from this.

5. Health trusts should establish procedures to ensure that staff are able to make use of the opportunity for using routine enquiry regarding domestic violence in health settings when working with women. Health Visitors and Midwives working in Bromley should be enabled to attend the BSCB Domestic Violence and safeguarding children ½ day during 2010. IF there is lack of availability of courses then the trusts should ensure that the issues are addressed within single agency training or presentations by the MARAC leads with staff being identified to attend the training in 2011. They must be reminded of the need to refer to social care for any domestic violence in households where there is an unborn or under 1 year old.

6. Crying babies: Health visitors and GPs must be reminded about the impact of a crying baby on the ability of parents who themselves already have problems. An assessment must be made of the impact of the crying and support mechanisms.

7. Fathers as parents: Trusts must audit their records systems to establish how family links are made and to what extent fathers are included in pre birth assessments.

8. Trusts must ensure that assessment frameworks used by professionals during the perinatal period include racial and cultural issues.