Leicester, Leicestershire and Rutland Local Safeguarding Children Board

Executive Summary: Serious Case Review, Child F

1. Introduction

1.1 Child F died within a month of birth. The post mortem revealed the baby had sustained a skull fracture. The cause of death has not yet been established and there is a continuing criminal investigation. Arising from the death of Child F the Leicester, Leicestershire and Rutland Local Safeguarding Children Board (LLR LSCB) identified that there were useful lessons to be learned and so conducted a Serious Case Review.

1.2 The review was carried out in line with government guidance. LLR LSCB is committed to learning lessons from reviews in order to develop and improve how children are safeguarded through the work of professionals and agencies and the way in which they work together. It is equally important to learn from good practice and to build on this. The review has tried to identify any changes which need to be made for the future.

2. The Serious Case Review

2.1 Each agency that had been involved with the child was asked to do a review, called an Individual Management Review. In the case of the Health Services this was a Combined Health Services Management Report. The reviewer had to be independent. All the records relating to the family were read. Some of the workers and their managers were spoken to. The reviewers' responsibilities were to be thorough, objective and critical in order to identify practice which did not meet the required standards as well as good practice. It was also important to understand why certain actions were taken and decisions made. The reviewers then produced chronologies, (what happened and when), of their agency's involvement and wrote a report of their findings.

2.2 The Serious Case Review Panel, made up of representatives of the LLR LSCB, who had no direct line management responsibility for the case, and the Individual Management Reviewers, considered all the reviews and analysed the professional practice and the way in which the agencies worked together. The group was joined by an independent person, the Overview Author, who was not employed by any of the agencies. Their responsibility was to look critically at the reviews and work with the group to draw conclusions from the information and analysis and then to write an Overview Report. The Children and Young People's Service, the Police and the Health Services were represented on the panel.

3. Learning from the review

3.1 The review considered whether, with the benefit of hindsight, different decisions or actions by the professionals and agencies working with Child F might have led to an alternative course of events. It concluded that Child F's death could not have been predicted by the agencies. The circumstances of Child F's death are not yet fully understood so it is not known whether different actions by the agencies would have contributed to an alternative course of events. Although the agencies had had some previous contact with the family relating to parental drug misuse there was no information to suggest the parents posed a serious risk to the child.

3.2 The Individual Management Reviews identified where there had been good practice. The Overview Report acknowledged that once Child F was born there was no lack of involvement with the family by the agencies, with each worker doing what they said they would do.

3.3 The review, however, found that there were a number of lessons to be learned which have led to recommendations for the future. These are described under the following headings.

Thresholds for inter-agency referrals

3.4 The review concluded that, following Child F's birth, more immediate referrals to the Children's and Young People's Service and the Community Drug Team would have enabled information sharing, assessment and planning for the baby's discharge from hospital to be more effective.

3.5 The review identified differing views within the services about thresholds for referral. This highlighted the need for work to ensure clarity about thresholds, including developing a shared understanding about the boundaries of family support and child protection and the nature of the roles and responsibilities of key staff in the relevant services. In addition workers needed to be supported in building confidence to challenge actions and decisions when they had concerns.

Using previous information

3.6 The review has emphasised the importance of agencies identifying previous information which should be shared in order to alert workers to potential problems and contribute to assessments

The Assessment Framework

3.7 The "Assessment Framework" guides Social Workers in their assessment of children's needs. Assessments can be at different levels, Initial and Core. Core Assessments consider the child and their family situation in more depth and are used when there are concerns about a child's safety. The assessments need to be carried out within tight timescales to ensure

there is no delay in understanding and meeting the child's needs. All agencies who know the child and the parents are expected to contribute to assessments.

3.8 The assessment of Baby F's needs and the parents' capacity to meet them would have benefited if all the involved agencies had met together at an early stage in order to share information, consider the potential risks to Child F and how the family could best be supported. The assessment should have been at more depth and have looked at the role of the wider family.

3.9 In 'The Protection of Children in England: A Progress Report', March 2009, Lord Laming described how more needed to be done to ensure GPs were doing all they could to keep children safe. He emphasised the need for child protection training for GPs to be sufficiently rigorous to enable them to contribute effectively to a multi-agency approach to the well-being of children, including appropriate referral and information-sharing training. These comments are reflected in the findings of this review and other recent, local Serious Case Reviews which have identified that GP practices appear to be increasingly detached from inter-agency work and the child protection processes.

Knowledge and understanding related to parental drug misuse

3.10 'Hidden Harm – Responding to the needs of children of problem drug users', The Advisory Council on the Misuse of Drugs, 2003, gave the clear message that parental drug use can and does cause serious harm to children from conception to adulthood.

3.11 A number of features of this case suggest that the knowledge and understanding of non specialist workers about drug misuse needs to be extended. There was some reliance on stereotypical perceptions of drug users which may have influenced information sharing and assessment. There was a lack of shared understanding within and between the hospital services and the drug service about aspects of practice and the existence of protocols. The entrenched nature of drug misuse may also have been underestimated which led to over optimism about the parents' capacity to change their behaviour.

4. Recommendations

4.1 The following recommendations are based on the lessons learned from this review. They are for inter-agency action through the LLR LSCB and action by the individual agencies. There have been other recent, local Serious Case Reviews where there are similar conclusions and this is noted in the recommendation.

LLR LSCB

4.2 **Recommendations linked with thresholds**

The LLR LSCB to ensure that there is clarity about thresholds for referrals to the Children's and Young People's Service by the maternity services, the drug and alcohol services and the Children and Maternity Hospital Social Work Team, with a focus on:

- child protection and family support thresholds
- the understanding of roles and responsibilities
- building confidence in all workers to challenge actions and decisions when they have concerns

The recommendation should be linked to the existing LSCB Action Plan.

4.3 **Recommendations linked with the Framework for the Assessment of Children in Need**

The findings from this review relating to the use of the Assessment Framework should be incorporated into the existing LSCB Action Plan, with particular reference to:

- When Hospital Discharge Planning meetings should be used to support assessments
- The involvement of fathers and partners who may be less visible to agencies in assessment

4.4 The LLR LSCB should take steps to assure itself that the Assessment Framework is being applied as required by statutory guidance and ensure the quality and inter-agency components of Initial and Core Assessments.

4.5 **Inter-agency links with GP practices**

The LLR LSCB to use the findings of this review to link with the existing LSCB Action Plan to review the role of GPs in inter-agency work to safeguard children.

4.6 **Recommendations linked with information systems**

The LLR LSCB to use the findings from this review to link with the recommendation on information systems in the existing LSCB Action Plan, particularly in relation to retrieving information and ensuring that it is used to contribute to current assessments.

4.7 **Training in relation to drug use**

The LLR LSCB to review training needs in respect of working with adults and parents who misuse drugs and to ensure that the review encompasses the following areas:

- Identification of the training needs of specific staff groups
- Extending the knowledge base, with a focus on working with parental drug abuse
- The impact on babies and children of parental drug abuse

4.8 **Specialist posts**

The LLR LSCB recommends that the commissioners of Health Services ensure that the existence and effectiveness of specialist posts involving work with families where there is parental drug misuse are monitored through quality assurance processes.

4.9 **Conclusion of criminal investigation and contact with the family.**

The LLR LSCB will ensure the Serious Case Review process is re-established at the conclusion of the criminal investigation in order to consider the implications for the current conclusions and recommendations.

The LLR LSCB will make contact with the family as appropriate as the criminal process allows.

Individual Agency Recommendations

Health

4.10 Key issues from previous Leicester City SCR must be further re emphasised by relevant agencies and within inter-agency training:

- The need for discharge planning meetings, which focus on reviewing the risks on an inter-agency basis.

- The need to recognise the difference between passive “co-operation” and the active engagement of parents. The parents need to understand agencies concerns and what needs to change.

- If any professional feels that a decision is unsafe and a child remains at risk, they should raise this matter immediately with their appropriate manager.

- Key frontline practitioners who work with women who use drugs and alcohol should have the opportunity to attend specialist training

4.11 **Recommendation**

Any history of drug dependence in GP records should be highlighted to obstetrician and community midwife in charge of the case.

4.12 **Recommendation**

A protocol for the prescribing of methadone is agreed and implemented by UHL Maternity Services and the Leicestershire Partnership Trust Community Drug Team.

4.13 **Recommendation**

The role of the Midwife with a Specialist Interest in Drug Misuse (SIDM) should be reviewed by UHL Midwifery service in collaboration with Leicestershire Partnership Trust Community Drug Team.

4.14 **Recommendation (Specific to UHL)**

Systems are reviewed to ensure that the mother's GP is informed of all maternity bookings, including those undertaken in locations other than the GP surgery

4.15 **Recommendation**
Further work is undertaken with Health, Social Services and Drug and Alcohol Misuse services to establish referral criteria, where issues of welfare concern are raised.

4.16 **Recommendation**

That the revised system for raising and managing concerns on safeguarding children's issues continues to be followed, utilising the alert system and Safe Discharge Planning meetings.

Children and Young People's Services

4.17 The Children and Maternity Hospital Social Work Team to review its processes to ensure that referral information and background information are gathered and read prior to an initial assessment taking place.

4.18 That discharge meetings are held prior to the discharge of babies on maternity wards where there are significant concerns expressed by ward staff about the ability of parents to care for their baby. Since 2008 there have been in place safe discharge processes with the use of an alert system and safe discharge planning meetings.

4.19 That referral processes between maternity services and the Children and Maternity Hospital Social Work Team are reviewed to ensure that appropriate referrals are made to Children's Social Care at the earliest opportunity.

4.20 That supervision and case management processes within Children's Social Care ensure that the assessment framework is applied when undertaking Initial and Core Assessments and is used to critically analyse family

presentation and to take into account all adults living in the household and relevant adults linked with the household.

4.21 That interagency advice and guidance and procedures which is available on the LLR LSCB website is accessed by Social Workers to ensure as full an understanding of drug misuse and parenting capacity as possible.

Leicestershire Constabulary

4.22 Leicestershire Constabulary should review its risk assessment processes for all vulnerable and violent people and ensure that they trigger appropriate referrals to the CAIU and other agencies to highlight any risks identified to the children.

4.23 This Serious Case Review should be used as an example to train officers to remind them of the need to record and use information about families.

4.24 The learning from this Serious Case Review should be incorporated into the current review of the intelligence handling systems within the CAIU.

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