Gloucestershire Safeguarding Children Board

Executive Summary

0309

IN RESPECT OF CHILDREN 'S' AND 'N'

SERIOUS CASE REVIEW CHAIR

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TABLE OF CONTENTS

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1. INTRODUCTION

1.1 Why are Serious Case Reviews undertaken? When children are seriously injured or die and abuse or neglect is known or suspected to be a factor, the Local Safeguarding Children Board is expected to conduct a serious case review into the involvement that organisations and professionals had with that child/ren and their family.

1.2 What is the legal framework for a Serious Case Review? Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards to undertake reviews of serious cases in accordance with procedures set out in Chapter 8 of *Working Together to Safeguard Children (2006).*

1.3 What is the purpose of a Serious Case Review? A serious case review is intended to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children

(Working Together to Safeguard Children (2006), Chapter 8, paragraph 8.3).

Serious case reviews are not inquiries into how a child was injured or died. These are matters for the Coroner's and Criminal Courts to determine as appropriate. Serious case reviews are not part of any disciplinary inquiry or process. Where information emerges in the course of the review that indicate disciplinary procedures should be invoked, each individual agency is required to instigate a disciplinary investigation and take any disciplinary action that may be necessary to safeguard and promote the welfare of children.

1.4 Why is an Executive Summary produced? Executive summaries are produced to provide information to the public about serious cases involving child abuse, to promote the accountability and scrutiny of public services responsible for protecting children, to help maintain public confidence in the process of internal review within public organisations, and to explain how effectively organisations worked together in a particular case to safeguard and protect the child/ren subject to the review.

1.5 Why is the full Serious Case Review Report not made public? The Gloucestershire Safeguarding Children Board and the agencies involved have a legal duty to balance the public requirement for accountability and openness with the need to:

- Ensure children in a particular family are not identified as a result of the report's publication;
- maintain confidentiality in respect of personal information contained within reports on the children, family members, and others;
- ensure that information that is not within the authority of the Local Safeguarding Children Board to share is not put into the public domain without legal authority, particularly if criminal or other court proceedings are ongoing;
- secure full and open participation from the different agencies and professionals involved.

2. BACKGROUND

2.1 HOW WAS THE SERIOUS CASE REVIEW IN RESPECT OF CHILDREN 'S' AND 'N' CARRIED OUT?

2.1.1 A Serious Case Review Panel, made up of senior staff representing organisations providing services to the children and families, was responsible for drawing up the terms of reference for the review and making sure that it was completed. Members of the Serious Case Review Panel are detailed earlier in this report.

2.1.2 Each agency involved with the children and the families was required to undertake an individual management review. The aim of the individual management review was to openly and critically examine individual and organisational practice to see whether this case indicates that changes could and should be made. This exercise involved interviews with staff and a detailed examination of agency records. Each individual management review contained recommendations for those organisations, where lessons learned need to be acted upon.

2.1.3 The following agencies produced individual management reviews as part of the serious case review process:

- Gloucestershire Children and Young People's Directorate, Social Care
- Gloucestershire Children and Young People's Directorate, Education
- Gloucestershire NHS Foundation Trust
- NHS Gloucestershire
- Children and Families Court Advisory Support Service

Each individual management review included a chronology of the agency's involvement.

2.1.4 An Overview Report was commissioned by the Serious Case Review Panel. An independent author was appointed who considered the factual information, assessed the quality of the individual management reviews, analysed the data and identified lessons to be learned, good practice, and recommendations for action. Members of the Serious Case Review Panel produced an integrated chronology of all agency involvements with the children and family. The Serious Case Review Panel considered all of the individual management reviews, the overview report produced by the independent author, and recommendations made.

2.1.5 The findings were presented to the Chair of the Gloucestershire Safeguarding Children Board, and to the Board itself. An action plan was drawn up and arrangements will be put in place to monitor progress in the delivery of the action plan through the Monitoring and Evaluation Sub Group of the Gloucestershire Safeguarding Children Board.

2.2 BRIEF OVERVIEW OF THE CASE.

Child 'S' had a range of complex disabilities. Most of Child 'S's life was spent in care. The child lived with the same foster carers from 2001 until the child's death in 2008. It was as a result of the Child Death Review process that it became evident there had been serious issues around multi-agency working throughout the last four years of child 'S's life. Concerns were expressed that the treatment by the foster carers and by the consultant paediatrician may have reduced child 'S's quality of life and contributed indirectly to the child's death. There has never been a concern that child 'S's death was as a direct result of any action taken by any of the individuals involved in the child's care. Child 'S' died under the age of ten, as a result of natural causes.

Child 'S' had problems with feeding and concerns were first raised about the feeding regime when the child started attending Special School in 2002. It was the view of the school and of the Speech and Language Team that child 'S' may have been aspirating (the process whereby food enters the lungs). This can lead to choking and has other serious medical implications. It was the view of the Speech and Language Team that a video fluoroscopy should take place, a simple procedure which would ascertain whether child 'S' was aspirating. The foster carers did not want the procedure to take place. It is understood they believed if child 'S' was tube fed, the consequence if the child was found to be aspirating, it would reduce the child's quality of life. The consultant paediatrician also appeared to believe that the foster carers would no longer care for child 'S' if the child had to be tube fed. The consultant paediatrician maintained there was no need for child 'S' to have a video fluoroscopy for the next five and a half years, despite constant opposition from others and against the advice of another consultant paediatrician. The consultant paediatrician finally agreed to the procedure taking place in 2008 and it did so shortly before child 'S's death. The video fluoroscopy concluded that child 'S' was aspirating.

Child 'N' is a child Looked After under S.31, Children Act, 1989, therefore Gloucestershire County Council has shared parental responsibility with the child's

parents. Child 'N' has been living with the same foster carers as child 'S' since 2004. Child 'N' also has complex disabilities.

Both children had limited communication skills and were not able to express their views verbally.

This case is significant for the unresolved issues that continued for many years and for the misconception that foster carers have the legal jurisdiction over a child they care for.

2.3 TERMS OF REFERENCE FOR THE SERIOUS CASE REVIEW.

Each agency was asked to consider:

- Which agencies have worked with 'S' and 'N' and their foster carers?
- Whether the practice was sensitive to the racial, cultural, linguistic and religious identity of the children and their families?
- The nature of the services offered to the children and adults. Were there any gaps in provision and were services provided appropriate?
- Separate factual chronologies of the actions taken by each agency and a combined chronology of actions taken by all involved agencies.
- If the decisions and actions taken in this matter were/are in line with the policies and procedures of individual agencies and the Gloucestershire Safeguarding Children Board?
- Whether the services provided were child-centered and whether the voice of the child was listened to?
- How inter-agency communication and working together impacted on the provision of services and the welfare of the children in this matter?
- Whether there were any cross agency issues relating to communication and the provision of services?
- The level of cooperation of significant adults, particularly the foster carers, with the services provided.
- To recommend appropriate single or inter-agency action in light of the findings.
- To assess whether other action is needed by any agency.

- The review should include whether the birth parents were involved and supported in any decision-making processes, in line with their parental responsibilities.

3. SUMMARY OF FINDINGS FROM THE REVIEW

3.1 Practice issues arising from the case

Professionals working with child 'S' were either unclear that the child's parents retained full parental responsibility and that the child was accommodated under S.20, Children Act, 1989, or they willingly allowed the foster carers to control the circumstances of their foster child, over whom they had no legal jurisdiction. The foster carers received no specialist disability training from Social Care.

There is little evidence that Child 'S's parents were involved in the meetings, or the discussions held by Health and Education. This is particularly evident in the workings of the consultant paediatrician, who appeared to make decisions based on the views of the foster carers. The foster mother was given powers that were not warranted. She was given expert status by the consultant paediatrician that was not warranted. The consultant paediatrician accepted her view that child 'S' was not aspirating and therefore there was no need for the video fluoroscopy. The foster mother had no medical training, she had no specialist training in caring for children with complex medical needs and child 'S' was found to be aspirating.

Child 'N' was a child Looked After under S.31, Children Act, 1989 and therefore the Local Authority had shared parental responsibility, with the parents. Again the foster carers had no legal jurisdiction and yet were erroneously allowed to make decisions on the child's behalf. Many of the same issues arose with child 'N' as had arisen with child 'S', between the foster carers and the professionals.

The statutory Looked After Children reviews for child 'S' were well attended by professionals, differences between them were addressed but not resolved. This case needed one of the professionals to take control and ensure differences were resolved. It was within the remit of the independent reviewing officer to do this. Whilst some workers did discuss their concerns with their senior managers, issues remained unresolved. At no point did any professional log a welfare concern with

Gloucestershire Safeguarding Children Board, despite serious concerns about the safety and welfare of 'S'.

The Looked After Children reviews in respect of child 'N' were not used to their greatest effectiveness. There were ongoing and unresolved issues such as the child's feeding, pain relief and poor school attendance, at times.

The Speech and Language Team followed their procedures, in terms of withdrawing their feeding service, as it was refused by the foster carer, who did not have the legal right to do so. Those procedures ensure staff members are protected but do not protect the child, or put the child's needs at the center.

Generally speaking, agencies were not taking a child-centered approach, with either child, therefore they were not acting in the best interests of the children. The focus was on the needs of the adults, not the children. The children's needs were not heard.

Gloucestershire Children and Young People's Directorate did not follow procedure when placing child 'N' with the foster carers. They had only been approved by the Foster Care Panel as short-term carers and the Panel had also stated "the placement of two severely disabled children should be avoided." There was no occupational therapist assessment and no review of the carers capabilities.

On one occasion child S was seen at school with bruises on her arms and this was not followed up, explanations of the foster carers were accepted.

Inadequate recording in Social Care has made clarity difficult. Illegible recording in some health reports made clarity difficult for the Gloucestershire NHS Foundation Trust individual management review author.

Decisions in this case were made based on presumptions. There was a presumption that the foster mother was an expert in children with complex disabilities and should be deferred to. There was a presumption that child 'S' would not be able to remain in the same foster placement, if he had to have a gastronomy (tube feeding). There was a presumption that child 'S' would not be able to remain at the same school, unless the video fluoroscopy took place.

The foster carers have been done a disservice by Social Care. It is the responsibility of the Fostering and Adoption Service to highlight concerns and address them as they arise and more formally at the annual foster carers review. This has not happened and this case was allowed to drift. The foster carers exerted their authority because they were allowed to do so.

3.1.1 Good practice identified

Child ' S's parents were invited to all of the statutory Looked After Children reviews arranged by Social Care. The reviews were also well attended by professionals.

The Education Service deemed that child 'S' would not be suitable for home school, despite the wish of the foster carers to home school the child. Child 'S' had limited communication skills and would be isolated and not seen regularly by professionals, so was the conclusion of the Home Education Service.

There are examples of professionals attempts to keep matters child-centered. The school used a communication passport with both children. The independent reviewing officer made efforts to ensure child 'S' attended the Looked After Children reviews. A teacher presented one of the reviews with a series of photographs of the child, at the beginning of the review that demonstrated how she communicated.

A multi-agency decision was made at child 'S's final Looked After Children review that an independent advocate should be appointed. This was a decision taken in the child's best interests. (It would have been more beneficial to child 'S' if it had been made several years before.)

3.1.2 Lessons learnt and recommendations for action

Lesson 1:

A lack of understanding about a child's legal status can lead to decisions being made by those without jurisdiction. Birth parents, with whom it can be difficult to engage, can be ignored and their views not heard. Foster carers can be given powers that legally do not belong to them.

As long as the birth parents retain parental responsibility their views should be sought and if a child is accommodated under S.20, Children Act, 1989, the birth parents retain full parental responsibility.

For children Looked After by the Local Authority under S.31, Children Act, 1989 responsibility must rest with the Local Authority after consultation with the parents, where appropriate.

It is the role of the adoption and fostering officer to address any issues that are impacting on the child's welfare as part of an ongoing process. These issues should then be addressed formally at the annual review.

The independent reviewing officer and the adoption and fostering officer should have been more rigorous in challenging concerns about the children and the foster carers.

- **Evidence:**

It is clear by the events that took place in child 'S's life that those working with child 'S' did not understand the child's legal status. Even though references were made to the birth parents "parental rights" by the consultant paediatrician, it is clear by the actions of all the agencies that they were unaware that only the birth parents had parental responsibility. It is also clear that the foster mother was allowed to take control of the situation and make decision that were not hers to make and were not always in the children's best interests.

Recommendation 1:

Adoption and Fostering Services have to ensure that their adoption and fostering officers and their carers understand and do not overstep their remit of responsibilities regarding the care of children.

Adoption and fostering officers need to address any issues that may arise with foster carers on an ongoing process and then on a formal basis at their annual review.

For children accommodated under S.20, Children Act, 1989 there should always be deferment to the parents and parents should be supported and empowered to make informed decisions of their own.

All social workers and managers in the Adoption and Fostering Service to receive up to date training regarding this issue, within the next six months. In addition to this Gloucestershire Safeguarding Children Board must include an explanation of the differences between S.20 and S.31, Children Act, 1989, as well as the legal definition of parental responsibility, in their multi-agency training. Single-agency training must also include this.

Lesson 2:

If there are not clear processes to escalate an issue, or to challenge, the answer can be to withdraw services and allow the difficulties to continue. Staff need a clear understanding of what to do if there are unresolved issues.

- **Evidence:**

The Speech and Language Team withdrew their feeding service but said that child 'S' would remain on their communication caseload. This was in line with the Royal College of Speech and Language Therapist Guidelines, 2005. It does not appear that any of the other professionals, nor the foster carers understood what this

meant; it merely led to confusion because they remained involved, to a certain extent.

Where there are differences of opinion between professionals, foster carers and parents these should be resolved at the Looked After children reviews. They should not be allowed to drift. The consultant paediatrician concurred with the foster carer that a video fluoroscopy was not in child 'S's best interests because he was concerned that the foster carer would no longer care for child 'S' if he had a gastrostomy and he believed it to be an excellent placement. The consultant paediatrician should have discussed his concerns with the social worker and would have been able to do so and with other professionals, if he had attended the Looked After Children Reviews, prior to 2008.

Concerns were first raised about child 'S's feeding at the beginning of 2003, when he first attended his Special School. These concerns continued until then end of 2008, when he finally had the video fluoroscopy. It took five and a half years to resolve this issue.

Recommendation 2

The South West Safeguarding and Child Protection Group escalation policy must be promoted by agencies. Agencies will be responsible for measuring its use, evaluating its effectiveness and report back to Gloucestershire Safeguarding Children Board, within agreed, ongoing, realistic timescales. In addition to this, Gloucestershire Safeguarding Children Board needs to include details of the escalation policy in their multi-agency training.

Lesson 3:

The voice of the child must always be heard and workers must take a child-centered approach. In a situation where there is a child with non-verbal skills

workers must be more enterprising and more vigilant. The use of a communication passport is an excellent tool, as is the appointment of an independent advocate. Child 'N' had bruises to her arms which were not followed up. Children with disabilities, particularly multiple disabilities are more vulnerable to abuse. (Westcott and Jones, 1999; Balogh et al, 2001; Morris, 1998; Department of Health, 1999).

Evidence:

Child 'S's needs were not being heard. Until the end of November, 2008 it was the needs of the foster carer that were ultimately being met. This would also be true of child 'N'. Her pain management was giving professionals concerns, her feeding method and the potential for her to choke at night, which the foster carers were unwilling to monitor. It was their view that both child 'S' and child 'N' were light sleepers and any noise would wake them.

Recommendation 3

Agencies must ensure their processes are pro-active and child-centred and that adult issues do not take priority. Gloucestershire Safeguarding Children Board to ensure this recommendation is disseminated to all agencies, particularly front-line staff.