Gloucestershire Safeguarding Children Board

Serious Case Review

Executive Summary

0805

Aged 3 months

Overview Author
Richard Townsend
Independent Consultant
July 06

April was the youngest child of Jackie, her father was Brian. April died aged three months. Although the precise cause of death has yet to be established the Post-mortem has revealed that April had suffered serious injury, including several broken ribs, of different ages. These injuries are thought to be non-accidental. Jackie is a known drug user and she suffers serious health problems related to excessive drug misuse.

Jackie has three other children. The oldest, Faye, is aged eight, her second child, a boy is aged six and her third child, a girl is aged four. Each child has a different father, all are known drug users, some were also known to be violent. When April died she was living in a household with her mother, her father, his adult brother and April's three other children.

In view of the concerns felt by professionals resulting from the lifestyle of Jackie and Faye's father a Child Protection Conference was held on Faye soon after she was born. Her name was included on the child protection register under the category of physical and neglect. Her name remained on the child protection register for six months and was removed after there were improvements in the family circumstances and after her mother had successfully completed a detox programme. Good interagency work took place with core groups held appropriately, although the Health Visitor was absent from several during this time.

From this period of child protection registration to the most recent referral, three weeks prior to the birth of April, five referrals are made to the then Social Services Department (referred to as Social Care) and eight welfare concerns (checks to the child protection register) are made. None result in sustained social work support. All are related to the impact of Jackie's substance misuse, concern about successive pregnancies and about poor school attendance. Other concerns were raised in school and by Health about developmental delay of the older children. Jackie had a history of missed appointments and a heavy reliance on male partners to take responsibility for much of the care of the children.

The review concluded that there were problems of communication between agencies, Social Care, Health, the Police and Probation. When referrals were made assessments did not give due consideration to previous concerns – that demonstrated that Jackie was not able to consistently but the needs of the children before her own needs and that she was not able to deal with the significant issue of substance misuse. Referrals were closed without interagency plans being put in place and on assumptions that other agencies were continuing to work with the family.

The principle support role to the family throughout was carried by Health. In the review period the family had 5 Health Visitors due to the family changing GP Practices and to the move of house. Social Care input appears to have been reactive with the case being opened and closed on a number of occasions. For a period of six months the family were open to Social Care but the only contact with the family was by telephone. The Social Care IMR states "that while it could be argued that the decisions not to allocate a social work service were at the time appropriate what was known about Jackie's history, her pattern of disengagement with services and her failure to priorities both her own and her children needs, that there was an over reliance on other agencies to support and monitor the family." At other times following assessment Social Care appear to have made assumptions that Health Visitor's would fulfil the lead professional role without consulting them.

The significance of missed appointments and Jackie's unavailability, her reliance on her male partners to deal with professionals, was lost because of poor recording and a lack of a

chronology. This re-enforces the view that had this type of information been available thresholds of concern would have been raised.

The problems experienced by the family were masked by the fact that Jackie was considered to be a good mother who showed warmth, affection and respect for her children .The development of the three older children was generally satisfactory. However when Jackie was unwell she was unable to take advantage of advice or carry through strategies for managing her children.

Concerns increased just prior to April's birth, a referral was made and a social worker allocated. By the time April was two months old a request for a child protection conference was made. However the advice from the Safeguarding Children Service was to hold a multi-agency meeting to pull together concerns and to agree a plan with Jackie and Brian that protected the children. The subsequent meeting was poorly attended (it did not include police or probation), though it did raise eighteen child protection concerns. The review concludes that this meeting should have been a strategy discussion and had it been so would have included the police. The family did not engage and a child protection conference was convened. April died before that meeting took place.

Subsequent to April's death an issue involving the Bristol University Confidential enquiry into stillbirths and deaths in infancy Project arose. April's early diagnosis was death by natural causes and personnel from the Bristol project prevented Social Care from carrying out a risk assessment on the other children in the house. Concern has been expressed about this in the review and the GSCB have been asked to raise this with the Bristol Project.

Summary of Concerns and Recommendations

Failure to initiate a Strategy Discussion or Child Protection Conference at the appropriate time.
Concern was raised about the nature and time of the consultation between the Social Worker and the Child Protection Co-ordinator and the way the decision was recorded. Further that a Strategy Discussion should have been called at that time to pull information together in a more rigorous manner. It is recognised that the use of the Strategy Discussion is not embedded in work practice within Social Care, and that this needs to be addressed. The Strategy Discussion would have included the Police and Probation, given greater weight to the family history and may well have raised the threshold of concern leading to a quicker Child Protection Conference.

The review concluded that the GSCB should offer greater advice about the thresholds used to determine the use of Strategy Meetings and Child Protection Conferences.

Recommendation 1
Consultation with the Safeguarding Children Service about the need for a Strategy Meeting or Child Protection Conference has to be a formalised debate recorded on both the case file and the file of the Safeguarding Children Service.

Recommendation 2
Clear protocols should be developed and agreed by the Gloucestershire Safeguarding Children Board that once met would automatically trigger a Strategy Meeting to determine whether a case should be managed under sect. 17 or sect. 47 of the Children Act.

Recommendation 3
All case discussions between managers and professionals should be recorded on the case file and in particular any decisions in relation to the need to hold a Strategy Meeting and the reasons for that decision.

Recommendation 4
When convening any interagency meeting where drug misuse is a possible feature of concern, Police and Probation should be consulted to ensure all possible information is captured.

Risk assessment and the need to include all information, including the historical perspective.
The Review recognised that at times agencies (Social Care and Health) responses was reactive to individual crisis and that there was a failure to take account of previous concerns which could have led to a more proactive approach and the raising of levels of concern. This is exampled by the number of referrals to Social Care and to the Child Protection Register during the review period and which should have raised levels of concern. The absence of a clear chronology on all case files meant it was difficult for professionals to identify significant and recurring causes for concern. This point is linked to the need to collate the information held in the chronologies and would be the responsibility of the lead professional. The appointment of a lead professional should also mean that all information is brought together; i.e. Probation would not have been omitted and appropriate thresholds of concern identified.

Recommendation 5
Chronologies need to reflect a complete picture of agency intervention over time to help make sense of and analyse repeat patterns of referrals and escalating concerns. Such chronologies should be collated through the lead professional.

Recommendation 6
The significance of historical context and repeat patterns of referrals raising similar concerns needs to be considered and inform the Initial Assessment. It is essential to provide an overall understanding of whether the threshold for a service is met.

Recommendation 7
In adopting a Common Assessment approach the person who carries out the assessment should always identify and liaise with other professionals known to be involved to jointly agree a plan of action.

Recommendation 8
The Children's Safeguarding Board should ensure that clear protocols are in place with Professor F in order that all agencies are able to fulfil their professional and statutory duties.

Failure of professionals to communicate appropriately.
The Review highlighted that communication between the agencies was at times poor to non-existent while at other times was consistently good and effective. There was evidence of good individual contact between professionals, a lot by telephone but also face-to-face. Multi agency meetings after the period of child protection registration of Faye were less effective than they might have been.

During the review period 5 referrals were made to Social Care but following Initial Assessment there appears to have been little feedback. The school were concerned that they had not been informed that Fay's name had been on the Child Protection Register, equally the school did not inform Social Care when Faye failed to attend school, without any explanation, for 15 days even though the school were aware the children were vulnerable. The communication breakdown seems to have been at it's worse in the middle stages of the case with a clear improvement in the latter stages when the concerns for the children were increasing, although a clear omission at this time was the failure of the Police, Social Care and Probation to share information.

The Review clearly indicates that central to poor communication was the failure to establish who was the lead professional and who should convene meetings. The confusion was further aggravated for Health due to the fact that at any one time several Health Professionals were involved with the family including the GP.

Recommendation 9
Professionals and families need to understand who is the lead professional in the absence of Social Care. In all complex cases a lead professional should be appointed and even in a case where there is single agency involvement and several professionals in contact with the family a lead professional should be appointed for that agency. All relevant information should be collated by the lead professional and disseminated to all other involved agencies.

Recommendation 10
Where a decision is made that the threshold for Social Care intervention is not met following referral, this needs to be:

- **communicated clearly in writing and**
- **the referrer should consider a co-ordinated multi-agency or single agency response without Social Care involvement.**

Recommendation 11
Where parents/carers are known drug users and where there are vulnerable children information should be shared with nurseries and schools about any concerns. If there are no immediate concerns but there is an allocated Social Worker, contact details should be provided to the nursery/school.

Recommendation 12
Unauthorised absence from school should be reported to the Education Welfare Service in all cases, but for particularly vulnerable children, including those of drug using parents, a child welfare concern should be logged with the Safeguarding Children Service.

Recommendation 13
Communication between Midwives and GPs should be improved so that a midwife's concerns regarding a patient are shared with the GP.

Recommendation 14
Offender Managers should be proactive in contacting other professionals and agencies involved in cases where children may be at potential risk in order to share information, knowledge, assessments and plans.

Maintenance of records.

Problems about the recording information on files were identified for health, social care and education. Thus the task of making assessments over time was made more difficult. Clearly this is an unsatisfactory situation as it is essential that clear records a maintained for all children and particularly for vulnerable children and form a key tool in risk assessment.

Recommendation 15
All Social Care contacts, notes and action plans should be recorded, however briefly, with key points and subsequent actions noted.

Recommendation 16
Schools should be reminded of the importance of keeping up to date records of visits from other agencies and any concerns raised about children should be recorded in the child's file.

Recommendation 17
All Health Professionals should be reminded of the need to maintain legible records which should include negative contacts i.e. unsuccessful visits or telephone calls not answered. The legibility of Health Visitor records should be monitored as part of the child protection supervision process.

Maintaining a child centred focus.
There is a theme running through the Review that Jackie's problems i.e. drug misuse, risk from deep vein thrombosis and her periods of hospitalisation, at times deflected the professionals from focusing on the impact for the children of living in a household where drug taking was routine and the adults drug habit being linked to drug dealing. The emphasis on Jackie might also explain why so little is recorded in the records of health, social care and education about the various male adults that were from time to time were part of this household. There is a need to ensure that all professionals remain focused on the needs of the children and at the same time take account of all the adults in the household, not just the female carer. This is one of several training needs identified in the Review.

Recommendation 18
The Gloucestershire Safeguarding Children Board should review its existing training programme to ensure that it adequately addresses issues in relation to achieving the balance between working positively with parents, while at the same time ensuring the protection of the child and that delivering child protection plans remains the focus of intervention.

Recommendation 19
Schools should be reminded of their duty to ensure all staff receive training in Child Protection and that the Designated Officer should receive multi-agency training every 2 years.

Probation Service
Concerns were raised through the Probation internal management review about practices in relation to the various male members of the household and these need to be addresses by the Probation Service.

Recommendation 20

Learning points from the Probation IMR to be examined by Offender Managers, Middle Managers and ACO to identify training competencies, practice and monitoring issues in relation to the use of eOASys, risk assessments and risk management.

Police
Concern was raised about the level of information included in the police internal management review.

Recommendation 21
The Police should give consideration to the format, content and style of their IMRs. The current model is not in line with those produced by other agencies.

Duncan Siret
Safeguarding Children Manager
22nd June 06