CHILD D

A SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

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On behalf of the Portsmouth Safeguarding Children Board
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1. INTRODUCTION

1.1 This report is written following the death in December 2011 of a three week old baby, Child D. The cause of death was identified as Sudden Unexpected Death in Infancy.

1.2 The circumstances of the death of Child D, in a context of substantial involvement of various agencies with the family, led the Portsmouth Safeguarding Children Board (PSCB) to conduct a Serious Case Review (SCR) in line with the government's guidance[1].This is the Executive Summary of the final report from that Review.

1.3 The death of a child is of course distressing for their family and for staff who have known the family. This review has been assisted by the co-operation of Child D's family and the commitment of staff from all the agencies involved.

2. SERIOUS CASE REVIEW PROCESS

2.1 During January 2012 arrangements were made to appoint the independent people who are required to contribute to the conduct of SCRs. Mr Jimmy Doyle, who is the Independent Chair of the Portsmouth Safeguarding Children Board, agreed to act as Chair of the SCR Panel. Mr Kevin Harrington was appointed to produce the Overview Report and this Executive Summary. Further details can be found in the Overview Report.

2.2 It was determined that the following agencies should contribute to the Review. Those agencies with substantial and / or recent contact were required to submit full Individual Management Reviews whereas one agency with minimal involvement provided a report for background information.

AGENCY	NATURE OF CONTRIBUTION
Portsmouth City Council Children's Social Care and Safeguarding Service	Individual Management Review (IMR)
Portsmouth City Council Legal Services	IMR
Portsmouth City Council Early Years Service	IMR
Portsmouth Hospitals NHS Trust	IMR
Solent NHS Trust	IMR
General Practitioners	IMR
NHS Southampton, Hampshire, Isle of Wight & Portsmouth	IMR / Health Overview Report [2]

[1] Working Together to Safeguard Children (2010) – referred to in this report as "Working Together"

[2] Working Together (Paragraph 8.30) requires that in every SCR the appropriate Primary Care Trust should draw up a a health overview report focusing on how health organisations have worked together, which will also constitute the IMR for the PCTs as commissioners .

Hampshire Constabulary	IMR
Children and Family Court Advisory and Support Service (CAFCASS)	IMR
Portsmouth Home-Start	IMR
South Central Ambulance Service	Information report

2.4 The Panel determined that agencies should provide detailed accounts and analysis of their contact with the family from December 2008, the first time a child of the family was known to have suffered an unexplained injury, until the death of Child D. Agencies were asked to summarise any earlier contact with the family.

2.5 The key issues for consideration are set out, in summary, below:

1) the effectiveness of child protection processes (including in particular the pre-birth assessment of risk to Child D).
2) assessments and decision making
3) the responses of agencies to long-term concerns about neglect and abuse
4) communication between different agencies involved with the family
5) co-operation between different agencies including any organisational or resourcing problems
6) management support, oversight and accountability.
7) the extent to which the older children's experiences and views were established and taken into account.
8) analysis of the court process including decision making about Orders and the placement of Child D.
9) compliance with policies and professional standards in relation to safeguarding and promoting the welfare of children
10) sensitivity to racial, cultural, linguistic and religious identity

3. THE FACTS

3.1 Child D was the fifth child of her mother, Ms A. Her older children were from a previous relationship. Two of those children had suffered significant physical harm as infants. Those injuries were investigated but the investigations had not produced evidence sufficient to support criminal proceedings against any individual(s).

3.2 As a consequence of the injuries Ms A's children were made subject to formal child protection arrangements and went to live with members of her extended family. The family and the local authority became involved in legal proceedings about the children. There was a late, fundamental change in the position taken by the local authority in court, supporting applications for Residence Orders when they had previously sought the removal of the children from the care of their family. The courts eventually confirmed arrangements that the children should live with family members.

3.3 Child D was born soon after this and was made the subject of a Child Protection Plan. The local authority also initiated legal proceedings but an application for admission to care was withdrawn following legal advice. At the time of her death the courts had made Child D subject to an Interim Supervision Order and she was living within the extended family. On the night that she died she had been left sleeping in circumstances which were not safe. Her death did not result in any criminal prosecution.

3.4 It was clearly appropriate that a Serious Case Review be conducted in this instance. The child who died was only 3 weeks old but was subject to a Child Protection Plan. There was a history of substantial contact with her family which included the investigation of very serious, inflicted injuries to some of her half-siblings at an early age. There was evidence that agencies had not worked together to best effect in providing services to this family.

4. LESSONS LEARNED

4.1 No concerns arose about the care provided to Child D by her family but her death may have been prevented if “safe sleeping” advice had been followed.
* The Coroner's subsequent finding was that the child died of natural causes due to infection.

4.2 The history of agency involvement with Child D’s family is significant in understanding the events leading to the arrangements for her care. There were weaknesses in assessment and care planning. Working relationships between the Court, the Guardian in care proceedings and the local authority could have been more effective. Factors highlighted in the review, which may have resulted in an alternative care plan, remain relevant to strengthening future multi-agency practice.

4.3 Before Child D was born there had been a lack of detailed assessment, planning and review in agencies’ work with the family. Child Protection Plans were appropriately introduced but discontinued despite lack of co-operation or evidence of progress. Care planning became confused to the point where some agencies were unclear about the legal status of the children. The gradual breakdown of any productive working relationship between the family and most of the agencies involved was not explicitly recognised and tackled.

4.4 The input from Children’s Social Care services was substantial but became increasingly unproductive. Inexperienced staff were not well directed by their immediate managers or by organisational quality assurance arrangements. This made it all the more difficult to plan for and respond to the new challenges arising from the arrival of Child D.

4.5 There were several instances of concerns about unexplained injuries to various children of the family. There were weaknesses in the way these incidents were investigated, within and across agencies. Assumptions were made about the identity of the perpetrator without all avenues being adequately explored. Police interviews were not always well planned, so as to take account of the ages of the children involved.

4.6 There were multiple weaknesses in the advice and support provided by the local authority’s Legal Services. Concerns included lack of basic record-keeping, over-reliance on inexperienced and temporary staff, and elementary errors in the application of legal processes. The poor quality of legal advice and support contributed to delay and confusion throughout the conduct of the legal case. As with Children’s Social Care, this weakened the capacity of the service to plan for Child D.

4.8 The robustness of the legal proceedings was compromised by serious weaknesses in the work of Cafcass. Cafcass failed to make a thorough initial assessment of the case, not giving adequate weight to the historical evidence of causes for concern. The Children’s Guardian too easily accepted the

family's position, despite the evidence of serious inflicted injuries and other continuing concerns. This was compounded by an over-readiness to focus on the perceived failings of the local authority. There were weaknesses in routine recording and communications. The Guardian could have done more to work directly with the children, in order both to support them and to inform case planning.

4.9 The Review identified some unsatisfactory working relationships between Children's Social Care and a school. This may have contributed to a missed opportunity to build on positive relationships between the school and the family. It may also have contributed to failures in educational settings to follow basic child protection arrangements.

4.10 The SCR identified similarities with a number of issues identified in a previous review. The two reviews considered events which occurred during the same timeframe. The Panel noted that recommendations about these issues are part of a current action plan. A Safeguarding Peer Review in October 2012 will afford an opportunity to examine progress against the findings of both SCRs, either on a locality basis or across the authority.

4.11 The Panel reflected on whether the lessons learned from this Review indicated any systemic failures in the work with the family. There are specific factors, detailed above, which suggest difficulties in the co-ordination of work between key agencies. However, the Panel also heard of ongoing work in each of those services which suggest an encouraging potential to improve.

- Children's Social Care has worked to improve the quality and timeliness of assessments which are all quality assured before any proceedings are initiated. The supervision and support for newly qualified social workers has been strengthened.
- The quality and consistency of Legal Services support has been improved and steps are being taken to re-establish a more constructive relationship between the local authority and the courts.
- Cafcass has taken steps to review service arrangements and has been subject to a recent inspection which rated assessment and service responses as good.

These findings left the Panel optimistic about the development of more effective inter-agency working into the future.

5. PRIORITY RECOMMENDATIONS FROM THE SERIOUS CASE REVIEW

5.1 The full Overview Report sets out a number of recommendations which reflect the views of the SCR Panel and the independent Overview Report author. That report also details all the recommendations from the reviews carried out by contributing agencies. The recommendations which address the key concerns arising from the Review are set out below.

5.2 The Portsmouth Safeguarding Children Board should support the renewed delivery across all partner agencies of initiatives to promote “safe sleep”.

5.3 The local authority (Legal Services) must ensure that Legal Services are equipped to provide adequate support to front-line services so that the local authority can meet its statutory responsibilities to protect and promote the best interests of children.

5.4 The local authority (Children’s Social Care services) must ensure that there are clear and reliable arrangements for assessment and follow-up where pre-birth child protection concerns are identified.

5.5 The local authority (Children’s Social Care services) should introduce arrangements in Children’s Social Care services for routine review, above first-line management level, of the progress of cases involving care proceedings.

5.6 The Portsmouth Safeguarding Children Board should introduce multi-agency quality assurance initiatives directly aimed at appraising how well agencies are working together.

5.7 The Portsmouth Safeguarding Children Board should evaluate the reports arising from this review of unsatisfactory working relationships between Children’s Social Care services and a school, and develop, if necessary, a protocol to strengthen effective communications and understanding of the arrangements for escalating concerns.