

**HARINGEY LOCAL
SAFEGUARDING CHILDREN
BOARD**

**SERIOUS CASE REVIEW
'CHILD A'**

EXECUTIVE SUMMARY

November 2008

1 INTRODUCTION

1.1 CIRCUMSTANCES OF CHILD A'S DEATH

- 1.1.1 On 03.08.07 at approximately 11.30am Ms A (mother of child A - a White child of Irish ethnic origin) called the London Ambulance Service. Attending paramedics took the apparently lifeless body of child A (aged seventeen months) to the North Middlesex University Hospital.
- 1.1.2 In spite of efforts by Ambulance and hospital staff to revive him, child A was pronounced dead at 12.10pm. A post mortem completed on 06.08.07 offered as a provisional cause of death 'a fracture / dislocation of the thoraco-lumbar spine'.
- 1.1.3 At the time of his death, child A was subject of a multi-agency child protection plan.
- 1.1.4 Police enquiries established that at the time of child A's death, Ms A's boyfriend Mr H lived at her address and Mr G, his three children and a fifteen year old female whom he described as his girlfriend had been staying there since 17.07.07.
- 1.1.5 Ms. A, Mr H and Mr G have been charged with murder and causing or allowing the death of a child.

1.2 ARRANGEMENTS MADE FOR THE SERIOUS CASE REVIEW

- 1.2.1 As required by chapter 8 of the government's statutory guidance *Working Together to Safeguard Children 2006* Haringey's Local Safeguarding Children Board immediately initiated a serious case review and on 06.08.07 formally notified OfSTED (the relevant regulatory government authority) of that decision.
- 1.2.2 A sub-committee of the Local Safeguarding Children Board was convened and on 08.08.07 agreed the scope of the review and initiated formulation by each relevant agency, of individual management reviews of the respective services provided to child A and his family.
- 1.2.3 Agencies contributing to the serious case review were:
 - Haringey's Children and Young People's Service (Children's Social Care & Schools Services)
 - Haringey's Strategic & Community Housing Prevention & Options Team
 - Metropolitan Police
 - Haringey Teaching PCT

- North Middlesex University Hospital in Partnership with Great Ormond Street Hospital for Children NHS Trust
- Whittington Hospital NHS Trust
- Family Welfare Association
- Great Ormond Street Hospital
- Haringey Legal Services

1.3 CONDUCT OF SERIOUS CASE REVIEW

- 1.3.1 CAE Ltd (an independent consultancy) was commissioned to collate agencies' individual management reviews and develop an overview report for approval by the serious case review sub-committee and subsequent ratification by Haringey's Local Safeguarding Children Board.
- 1.3.2 Child A's father was offered and declined an opportunity to contribute to the review and his mother did not respond to an invitation to do so.
- 1.3.3 The sub-committee recognised a need for, commissioned and received expert medical opinions about particular aspects of child A's receipt of health services and those judgements are reflected in the recommendations for action by Haringey's Local Safeguarding Children Board and specified member agencies.
- 1.3.4 The serious case review sub-committee met on seven occasions in the period from September 2007 to July 2008 and agreed the draft overview report and executive summary. Final amendments were made in October 2008 to improve the specificity of paragraph 4.2.3 and to ensure that the executive summary provided sufficient anonymity in line with legal advice.
- 1.3.5 The executive summary will be published at the conclusion of the criminal trial of Ms A, Mr H and Mr G.

2 SUMMARY OF AGENCY INVOLVEMENT

- 2.1.1 Ms A separated from her husband in the summer of 2006, from which time she had undertaken the care of their four children, a boy (child A) and his three older siblings.
- 2.1.2 There were no concerns about the welfare of any of the children in the family prior to mid December 2006, when child A (then aged nine months) was presented at a hospital with a head injury and bruising, considered by medical staff to be suggestive of non accidental injury.
- 2.1.3 Child A remained in hospital for four days until discharged to the temporary care of a family friend pending completion of multi agency enquiries some six weeks later. At that point the Police investigation was continuing, but had not identified any perpetrator of child A's injuries.
- 2.1.4 Following the above incident and a consequent initial child protection conference on 22.12.06, child A and his youngest sibling became subject of child protection plans. From that point Ms. A and her children had extensive involvement with professionals from local agencies particularly the Police, Children & Young People's Service and primary, community and acute health service providers.
- 2.1.5 From the time of child A's first presentation at hospital, observations and assessments of the relationship between Ms A and her children remained largely positive and she was considered to be co-operating with the child protection plans.
- 2.1.6 Various professionals noted that child A was an active child who was observed to throw his body around and head-butt family members and physical objects. This appeared to support Ms A's concerns that her son suffered frequent accidents due to being an active, clumsy child with a high pain threshold. From March, a main element of the child protection plan was to obtain a developmental paediatric assessment, to ascertain if there was an organic reason for such behaviour.
- 2.1.7 With one exception, the two elder siblings both under eight years old, did not give cause for significant concern. They attended school regularly and there was no evidence from schools of any concerns about their home life or any indication of changed circumstances.
- 2.1.8 The exception to the above apparently reassuring perception was an incident in March 2007, when Ms A was seen to slap her eldest child. This child was consequently made subject of a child protection plan in March 2007.

- 2.1.9 In early April 2007 child A was presented at a hospital for a second time this time with a swelling to the left side of his head, understood to have been the result of hitting his head on a fireplace after being pushed by another child. He also had bruises and scratches to face head and body, a rash to his face and neck and it was noted he had head lice. He was admitted for two days for observation and treatment with antibiotics and with the agreement of Haringey's Children & Young People's Service, discharged home.
- 2.1.10 There was a further significant event in early June 2007 when a social worker observed marks on child A, informed the Police and, with Ms A's co-operation arranged and attended a medical examination, at which it was concluded that there was a reasonable probability that some of the bruising was due to abuse.
- 2.1.11 On 04.06.07, so as to ensure no unsupervised contact between child A and his mother, Haringey's Children & Young People's Service and Police agreed temporary safeguarding measures for child A involving a childminder and the same friend who had previously provided temporary care of him.
- 2.1.12 Also agreed at that point, and confirmed at the review child protection conference a week later, was the need to complete the still outstanding developmental assessment, to obtain legal advice on the justification for initiating protective legal proceedings and to learn the result of then ongoing police investigations.
- 2.1.13 Police enquiries with respect to potential perpetrators of child A's injuries both in December 2006 and June 2007 proved inconclusive and were ultimately completed in July 2007, with no criminal charges being preferred against any individuals.
- 2.1.14 Haringey's Children & Young People's Service obtained legal advice on 25.07.07, which indicated that on the basis of the information provided, the threshold for initiating Care Proceedings (a Care Order would have meant that the local authority would have shared parental responsibility with the child's parents and would have had the authority to remove child A) was not met.
- 2.1.15 Child A was seen by a paediatrician on 01.08.07, for the purpose of the developmental assessment. The paediatrician judged that he was unwell and miserable with a possible viral infection and partly healing scalp infection. The doctor completed a history, prescribed medication, arranged for various tests to be made and a follow up appointment made to complete the assessment.
- 2.1.16 Child A died before the intended follow up appointment was made.

3 LESSONS LEARNED

- 3.1.1 The absence of previous concerns about Ms A's four children and the positive observations of her parenting led to a high level of trust of Ms A. This was further reinforced by her predominant behaviours and presentation (the current criminal proceedings may reveal whether the positive picture was more apparent than real) i.e., her:
- Co-operation with most professional visits and appointments
 - Positive response to offers of help
 - Frequent initiation of communications with professionals, often relaying information between them
 - Openness of manner
- 3.1.2 As a consequence of professional perceptions of Ms A, coupled with the lack of an identified perpetrator, child A's injuries were perceived to be largely a consequence of insufficient supervision and of his own observed behaviours. The latter led to concerns about a potential organic causation of child A's bruising and injuries and prompted the involvement of the Specialist Child Health Service (SCHS).
- 3.1.3 Within the above context, new incidents were interpreted in terms of the existing understandings of the family dynamics, with insufficient attempts to use the incidents to prompt re-assessments.
- 3.1.4 All the professionals working with the family understood the household composition to be Ms A and her four children. Although it was known that a Mr H was a friend, neither his intimate relationship with Ms A nor his presence within the household, had been discerned by any professionals.
- 3.1.5 With the benefit of hindsight, the indication that Mr H may have been present in the household since February 2007 (current finding of the Police investigation following child A's death) offers a new perspective.
- 3.1.6 It should be noted that during the last month of his life, Ms A presented her son to health professionals eight times, and in his last week, he was seen by a social worker and a paediatrician. None of those professionals identified major concerns about child A's health and well being.
- 3.1.7 It is of concern that during this critical period the persistence of the sores on child A's scalp did not raise questions about the effective application or appropriateness of the various medications prescribed.
- 3.1.8 Most critically child A was seen on 01.08.07 by a community paediatrician for the purpose of the long awaited developmental assessment. Expert medical opinion commissioned during the course of this serious case review concluded that a diagnosis of abuse should have been made at that point.

- 3.1.9 This serious case review has revealed clear evidence of appropriate communication between and within agencies, as well as weaknesses in specific areas of information flow e.g. transmission of information to the Police 'Child Abuse Investigation Team' and between those directly involved in implementation of the child protection plan for child A.
- 3.1.10 With the benefit of hindsight, a number of key issues can be seen to have compounded the risk to child A including:
- Limited efforts made by professionals to involve child A's father in the early period of intervention
 - Trust and responsibility placed by Haringey's Children & Young People's Service in a family friend, with insufficient assessment, monitoring and review of her ability, role and performance
 - The pervasive belief that child A's injuries were caused by lack of supervision and his own behaviour and the lack of adequate re-assessment of the household following further injuries and bruising
 - The inability to identify and prosecute a perpetrator of child A's injuries
 - Delay in an adequate referral to and provision of the required Specialist Child Health Service appointment
 - Delay in holding a legal planning meeting and advice subsequently provided that the threshold criteria for obtaining a Care Order under s.31 Children Act 1989 were not satisfied
- 3.1.11 The quality of the work of the different agencies in this complex case, varied between and within them. Numerous examples of good practice within all agencies were found and have been acknowledged in the analysis provided in the main report.
- 3.1.12 The main finding of this serious case review is that, despite a great deal of professional input, the conclusions of the various assessment processes had not reached an adequate understanding of the:
- Cause of child A's injuries and bruising
 - Nature of Ms A's relationship with Mr. H and the extent of his involvement in the family
 - Value of the input by the family friend who provided alternative care in December 2006 and oversight of child A after the June 2007 incident
- 3.1.13 There were many factors that contributed to the inability of the agencies to understand what was happening to child A. With the possible exception of the paediatric assessment of 01.08.07, none on their own were likely to have enabled further responses that might have prevented the tragic outcome. The factors in combination contributed to the lack of understanding of the family's functioning and consequently compounded the risk to child A.

- 3.1.14 The reality was that local professionals were wholly unaware that Mr H had been living with Ms A for some months; that five other individuals had been staying at the home for approximately a fortnight before child A died and that (according to expert medical opinion commissioned by Great Ormond Street Hospital in the course of this serious case review) child A had visible symptoms of physical abuse and chronic neglect in the week before his death.
- 3.1.15 Thus, although the review of this case has found that safeguarding structures exist across Haringey agencies and offer a sound framework for the implementation of required procedures, it has also identified scope for improving the detailed application of some processes.
- 3.1.16 The main report on which this executive summary is based, elaborates upon the above 'lessons learned'. The recommendations in the following section specify the opportunities arising from those lessons for strategic multi-agency action by Haringey's Local Safeguarding Children Board and for enhancing operational effectiveness in each of the local agencies that provided services to child A's family.

4 RECOMMENDATIONS

4.1 INTRODUCTION

- 4.1.1 Haringey's Local Safeguarding Children Board has sought to ensure that 'lessons learned' are disseminated without delay. Hence, the main serious case review report and this executive summary have been produced prior to the completion of current criminal proceedings and do not incorporate any relevant evidence that might arise in the course of the trial.
- 4.1.2 If the criminal proceedings present new evidence for the partners represented by the Local Safeguarding Children Board it is recommended that the serious case review sub-committee consider the need for an addendum to the main report. Any such further work should be undertaken by external consultants in accordance with chapter 8 of government guidance - *Working Together to Safeguard Children*.
- 4.1.3 It is understood that all the recommendations below have been accepted by the Local Safeguarding Children Board and are being implemented.

4.2 HARINGEY'S LOCAL SAFEGUARDING CHILDREN BOARD

- 4.2.1 Haringey's Local Safeguarding Children Board should initiate a multi-agency review of joint protocols and practice guidance for referrals, strategy discussions, core group meetings and child protection conferences in respect of:
- The need to clearly state concerns and professional opinions in referrals
 - Multi-agency involvement and attendance in discussions, meetings and conferences
 - Involvement of paediatricians and/or named or designated doctors at strategy discussions / meetings (of particular importance if there are different perceptions of the risk and a potential need for further independent comment)
 - The use of second, and if required, further strategy discussions
 - Ensuring the designated or named paediatrician is invited to a child protection conference if a referral for a paediatric assessment has been made / is being considered
 - Administration (to include timing, accuracy, circulation of records and secure maintenance of such circulated records)
 - Periodic multi-agency audit of administrative processes
 - Ensuring that core group members are informed within five days of any change in an agency's allocated worker

- 4.2.2 Single and multi-agency training programmes for those undertaking supervision in safeguarding work should emphasise the need for all staff to:
- Be constantly vigilant
 - Have an open and inquisitive approach, regardless of any assumptions arising from previous assessments
 - Be aware of the need to re-assess following new and cumulative incidents and changes of circumstances (such assessment to include checking the accuracy of basic information e.g. household composition)
 - Challenge colleagues within partner agencies if required
- 4.2.3 Haringey's Local Safeguarding Children Board should ensure that the Primary Care Trust has in place robust arrangements for each child subject of a child protection plan to have active oversight and monitoring of her/his medical treatment. The monitoring role should be undertaken by an appropriately trained medical professional i.e. a GP who should receive medical support from the 'lead GP for child protection' and when necessary, the 'named' or 'designated doctor'.
- 4.2.4 Haringey's Local Safeguarding Children Board should recommend to the London Safeguarding Children Board that the London Child Protection Procedures be revised to require Children's Social Care, to share information with Police if any new safeguarding concerns arise in the context of an ongoing criminal investigation of abuse or neglect.
- 4.2.5 Following the completion of court proceedings and identification of any additional lessons Haringey's Local Safeguarding Children Board should ensure these are disseminated by holding multi-agency briefing sessions for staff.

4.3 AGENCY- SPECIFIC

FAMILY WELFARE ASSOCIATION (FWA)

- 4.3.1 FWA management should be more consistently proactive in ensuring clarity about directions for FWA work from safeguarding meetings and, if there is insufficient clarity or absence of notes, must communicate this concern to line managers.
- 4.3.2 FWA family support staff and management must be more consistently proactive in communicating all issues of concern or apparent relevance to the key statutory agencies.
- 4.3.3 FWA staff and management need to be more consistently proactive in addressing communication and participation difficulties within the professional network.

- 4.3.4 All casework recording in respect of a child subject to a safeguarding process must be kept up to date and contain an analysis of events and actions in addition to clear chronologies and information about the service being provided.

HEALTH AGENCIES

- 4.3.5 When Haringey children are seen in hospitals and there are child protection concerns or they are subject to a child protection plan, medical reports should be copied to Haringey's Safeguarding lead professionals and the designated doctor for Haringey

Great Ormond Street Hospital (GOSH): responsible for the Specialist Child Health Service (SCHS) following transfer to GOSH on 01.04.08

- 4.3.6 The SCHS should, in liaison with referring agencies, review the current referral process for assessments to ensure that it is clear:
- That referrers need to be explicit about the nature and purpose of the referral
 - What information and documents are to be provided
 - That, when a child is known to be subject to a child protection plan, the SCHS paediatrician should endeavour to obtain all relevant information, liaise directly with the social worker and consider the advisability of her/his attendance at the appointment
- 4.3.7 The SCHS service should review its Operational Policy (dated August 2007) with a view to:
- Developing a waiting list priority system that acknowledges the needs of the child, including the implications of a child subject of a child protection plan and
 - Requiring referrers and any involved social worker to be consistently informed of any appointments offered and of any that are declined
 - Facilitating Haringey's Children & Young People's Service to fully understand the care pathways and its implications with regard to a s.47 enquiry
 - That ensures all communications from any professional regarding children waiting for an appointment are included within the child's record
- 4.3.8 All GOSH doctors involved in any clinics but particularly in core services within Haringey, Enfield and Camden should contact the original referral person if they require further information or clarification.
- 4.3.9 When concerns about child safeguarding arise during the course of GOSH lead clinical assessments children should not leave the assessment unit / clinic / ward unless those concerns have been resolved or an agreed plan for their safeguarding is in place.

- 4.3.10 Bruises and any other injury on any child should be documented on a body map by SCHS / GOSH examining doctors.

Haringey Teaching Primary Care Trust

- 4.3.11 GPs and other practice based staff should be reminded of the importance of sharing any early concerns raised by parents / carers about health issues that could reflect safeguarding concerns, with other health professionals involved, particularly health visitors, school nurses and community paediatricians – the GP practice training programme and briefing cycle should raise this recommendation.

GOSH – responsible for GOSH in Haringey (Children, Young People and Families Community Health Services) since 01.04.08

- 4.3.12 The Mellow Parenting programme should review current practice regarding the recording and sharing of information emerging from group focused work to ensure that relevant information is passed to health visitors and social workers – this should include reviewing the information leaflet to parents, which currently guarantees confidentiality.
- 4.3.13 Health visiting and school nursing should continue with their plans to develop the standards for service delivery to complex families and those families with children subject of a child protection plan, review the child protection supervision policy and arrangements and review layout and format of records.
- 4.3.14 Parallel growth percentile charts should be introduced by health visitors / school nurses and maintained in the records of children where there are concerns about growth, and those subject of a child protection plan and the growth policy should be updated to reflect this.

GOSH at North Middlesex University Hospital (NMUH): responsible for and managing paediatric staff at NMUH

- 4.3.15 NMUH should review, in consultation with Haringey's Children & Young People's Service and the Metropolitan Police, the structure and completion of its child protection referrals to ensure:
- All concerns are included
 - Fact is distinguished from parental explanations / assumptions
 - Professional opinions are provided
 - The intended purpose of the 'child protection summary sheet' is clarified i.e. internal and/or external communication
 - The content of 'child protection summary sheet' reviewed to maximise its efficacy

HARINGEY CHILDREN & YOUNG PEOPLE'S SERVICE

- 4.3.16 The Service should ensure that Police are informed of any new incidents of concern about a child if an allegation may constitute a crime and / or if the child is subject of a child protection plan and /or there is an ongoing police investigation.
- 4.3.17 The Service should develop detailed guidance regarding the use of family friends as temporary carers for children, during s.47 enquiries, involving a clear description of status and minimum standards of assessment, monitoring and evaluation.
- 4.3.18 Managers should ensure that all known parents are informed of concerns about their child, consulted about plans, invited to child protection conferences and included on core groups (and if a decision has been taken to exclude them from any part of this process, the rationale should be recorded).
- 4.3.19 Managers should ensure that for children subject to a child protection plan:
- All elements of the child protection plan should be implemented in accordance with the terms specified in the conference record and should there be any need to vary arrangements, such action must be authorised and recorded by the senior team manager in consultation with the conference chair
 - Any change of circumstance, including temporary change of accommodation, should be subject to an assessment as to its suitability and the need for any alternative safeguards
- 4.3.20 When a conference recommends a change to the frequency of visits in the child protection plan the chairperson must state the rationale for the change.
- 4.3.21 If a child protection conference decides (exceptionally) not to make all the children in a family subject of a child protection plan, the chairperson must ensure the rationale for the decision is recorded.
- 4.3.22 If a child subject to a child protection plan, changes school, a core group meeting should be convened at the new school within ten working days.
- 4.3.23 The service should review and update its guidance in relation to case recording, and set out how this will be monitored and audited.

4.3.24 To improve the conduct of child protection enquiries, managers and social workers should be reminded that:

- Agency checks and information sharing should be undertaken for each s.47 enquiry, even for a child already subject of a child protection plan
- A telephone call should accompany faxed or e-mailed reports to police in urgent cases
- All relevant agencies should be involved in the strategy meeting / discussion, with a flexible venue to facilitate attendance
- Paediatricians are to be invited to all strategy discussions that involve physical injuries
- The strategy meeting decision sheet should be distributed to all invitees
- The plan devised includes a strategy to discover the circumstances of any concern and this should usually include speaking with children in the household and checking household composition (even if known)

4.3.25 To improve safeguarding practice, managers and social workers should also be reminded that:

- All agencies involved in the delivery of services, as part of a child protection plan, need to be informed of new or repeated concerns and the initiation of any s.47 enquiry
- Regardless of conclusions of previous assessments each new incident / injury should prompt consideration for the need to share information and to initiate a s.47 enquiry
- All decisions taken about safeguarding a child, and their rationale, must be recorded; managers must ensure the records reflect the decision making process

4.3.26 Senior team managers should monitor the progress of an enquiry and ensure that further strategy discussions (and if appropriate meetings) are convened for all s.47 enquiries to:

- Review the progress of s.47 enquiries and associated police investigations
- Consider the continued need for any safeguards to be in place
- Agree any additional enquiries to be made
- Identify unresolved issues
- Agree outcomes of the s.47 enquiry

- 4.3.27 If any child is referred for a paediatric assessment as part of a s.47 enquiry or as part of the child protection plan, the social worker must ensure that:
- The paediatrician is informed of all relevant history, including any previous paediatric assessments and their conclusion and any past or current s.47 enquiries
 - There is direct communication with the paediatrician and discussion of the need for a social work presence during the examination
- 4.3.28 The Heads of Service should remind all relevant staff of the procedure in relation to legal planning meetings including:
- The requirement to adhere to agreed timescales and propose dates accordingly
 - Provision of all relevant documents and details of previous legal involvement

Schools

- 4.3.29 CYPS should circulate to all relevant schools and centres the requirement that all child protection related documents must be transferred to a child's new school or setting within five working days of it being identified.

Haringey Children & Young People's Service & Legal Services

- 4.3.30 Legal Services and Haringey's Children & Young People's Service should review cases involving a legal planning meeting every six weeks at 'legal casework meetings'.

LEGAL SERVICES

- 4.3.31 All staff in Legal should be reminded of the need to comply with case management and performance standards at all times including accurate recording, filing and adherence to agreed timescales.
- 4.3.32 The Legal Services office manual should be amended to clarify that related matter checks should include both specific case files and general advice files.
- 4.3.33 To facilitate effective monitoring, Legal Services should introduce a specific file category for legal planning meetings on its case management system.
- 4.3.34 A pro-forma legal planning meeting memo and guidance should be drafted for use by the lawyers.

- 4.3.35 Legal planning meeting memos should be sent within two working days of the meeting and copied to the lawyer's line manager, senior lawyers, social work team manager and senior team manager.
- 4.3.36 Legal planning meeting advice given by recently recruited lawyers (temporary and permanent) should be checked and approved by the senior lawyer during the first three months of conducting legal planning meetings after joining the team.
- 4.3.37 Pending a strategic review, Legal Services should ensure that sufficient numbers of lawyers with strong experience of acting for a local authority in childcare proceedings are recruited or alternative methods of service provision are explored.

METROPOLITAN POLICE SERVICE

- 4.3.38 Officers within the SCD5 Command should be reminded of the need to ensure that they accurately record all information during criminal investigations, including the need for photographs of scenes (including victims) in line with Standard Operating Procedures.
- 4.3.39 SCD5 Quality Assurance officer should review by 'dip sample' Haringey CAIT investigations to assess if these two investigations are reflective of the team's general standards.
- 4.3.40 Officers of the SCD5 Command should be reminded that they have the capability to request follow up strategy discussions during complex or protracted investigations.