SERIOUS CASE REVIEW
Executive Summary

RELATING TO AN09
ETHNIC ORIGIN: WHITE BRITISH

Published July 2010

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1 Introduction

This is the executive summary of a Serious Case Review (SCR) conducted by Nottinghamshire Safeguarding Children's Board (NSCB) under Chapter 8 of *Working Together to Safeguard Children* (2006) into a child referred to as AN09. This summary has been written by Richard Green who is a senior consultant employed by the National Society for the Prevention of Cruelty to Children (NSPCC) and thus independent of NSCB, and who also wrote the overview report. The overview report contains a comprehensive account and analysis of professional interventions in this family's life, the lessons to be learned and recommendations. It was presented to NSCB on 23/11/09.

NSCB recognises the importance of publishing a 'public domain' summary as a means of demonstrating its accountability. Equally, however, it is mindful of the absolute necessity of preserving the confidentiality of family members, specifically of the surviving sibling of AN09 and his mother. To that end any information which might identify the family has been excluded or presented in such a way as to prevent the family from being identified.

The purpose of this summary is to demonstrate how NSCB undertook this review, what lessons it has learned and what steps it will take to safeguard and promote the welfare of children in future.

AN09 was an infant who died whilst co-sleeping (sleeping in the same bed as one or more carers). An inquest into the death was held in February 2010, the coroner recorded a verdict of sudden unexpected death in infancy. AN09 and his sibling were subject to child protection plans at the time of his death under the category of neglect.

On 8/06/09 the independent chair of NSCB decided that an SCR should be convened as neglect was suspected to be a factor in the death.

2 Purpose and scope of the SCR

The purpose of a SCR is defined in *Working Together* as being to:

- Establish whether there are lessons to be learned about the way in which local professionals and agencies 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.
- As a consequence, to improve inter-agency working and better safeguard and promote the welfare of children.

The standing SCR panel set the following terms of reference for the review:

- the quality of antenatal engagement and care
- the quality of pre-birth assessments
- the quality of the hospital discharge plan
- the quality of the assessment of both children's ongoing welfare, health and development
- the quality of the child protection conference processes

- the quality and appropriateness of the protection plans
- the quality of the assessment of parenting capacity
- the quality of the assessment of the relevance and impact of mother's partners and the impact of the relationships on the overall parenting of the children
- the quality and impact of mother's then partner's relationship with the children
- whether interagency child protection procedures had been appropriately followed
- evidence that staff had access to and followed interagency guidance *on Drug and Alcohol Using Parents* (2008)
- whether any areas where policy, procedural, management and resource infrastructure within which agency involvement with AN09's family took place had a significant positive or negative impact on practice or the outcome for AN09 and family.
- diversity issues.

The standing SCR panel set the timeframe of the SCR from week 12 of mother's pregnancy to AN09's death. It further asked for any summary information in respect of mother prior to week 12 of her pregnancy, two of her partners (with whom she had relationships during AN09's life) and some members of her extended family.

3 How the SCR was conducted.

Individual management reviews (IMRs), written by managers who had no prior involvement with the case and no management responsibility for any involved professional, were received from the following 12 agencies:

- Nottinghamshire Children and Young People's Services (NCYPS).
- Broxtowe Borough Council
- Nottingham University Hospitals NHS Trust
- Framework Housing Association
- Derbyshire Constabulary
- Barnardo's Reach Out Leaving Care Service
- Sherwood Forest Hospitals NHS Foundation Trust
- Nottinghamshire Police
- Nottinghamshire County NHS Trust
- Citihealth Nottingham City NHS Trust
- Derbyshire Children and Younger Adults Department (DCYAD)
- Nottinghamshire Healthcare Trust.

The IMRs were based on review of agency records and, as appropriate, interviews with staff.

Brief written submissions were also received from:

- NHS Direct
- Nottinghamshire Emergency Medical Services
- East Midlands Ambulance Service.

Copies of a number of relevant documents were requested and received, including formal assessments conducted by NCYPS, child protection conference minutes and reports, and core group minutes.

A SCR panel was convened and chaired independently by the Head of Service for Children's Quality Assurance in Derby City. Three panel meetings were held to review all reports and to comment on drafts of the SCR report and executive

summary, and to construct a draft action plan. The following were members of the SCR panel, all of whom had no direct involvement with the family or management responsibility for the case:

- Assistant Director Children's Services Barnardo's
- Head of Housing, Broxtowe Borough Council
- Deputy Assistant Director, Derbyshire Children and Younger Adults Department
- Head of Public Protection, Derbyshire Police
- Service Director, Framework Housing Association.
- Associate Director of Social Care, Nottinghamshire Health Care Trust.
- Assistant Director for Children's Services, Citihealth NHS Nottingham City
- Head of Service, Social Care Fieldwork, NCYPS.
- Deputy Head of Public Protection, Nottinghamshire Police
- Deputy Director Quality and Governance, NHS Nottinghamshire County
- Medical Director Nottingham University Hospital Trust
- Service Director for Children , Sherwood Forest Hospitals
- Board Manager NSCB
- NSCB Development Manager
- Head of Service, Safeguarding and Independent Review, NCYPS.

The review was completed in just under six months, this being within the timeframe agreed by Government Office East Midlands. (An extension was agreed when the original overview report author became ill.)

4 Family involvement

AN09's mother was invited to meet with the original independent overview report author and NSCB Board Manager to contribute to the review, and accepted the invitation. Information and views provided by mother at that meeting were incorporated into the SCR overview report. A second meeting was offered to mother on completion of the review to share its findings and to share a copy of this summary.

The putative father of the children denied paternity and played no part in their upbringing.

Mother had two partners during the review period. However, she is no longer in a relationship with either of them.

For these reasons neither the putative father nor mother's partners were invited to take part in the SCR.

5 Brief summary of agencies' involvement

Many agencies were involved before and after AN09 was born, providing services and undertaking assessments.

When mother became pregnant with AN09, health agencies noted a number of concerns relating to her, the main one being her misuse of alcohol. This led to a referral to social care who undertook an initial assessment. Family support was provided to the family under a child in need plan.

However, following AN09's premature birth, concerns grew around the standard of care of him and his sibling. These concerns led social care to conduct a section 47 child protection enquiry. This in turn led to the convening of a child protection conference, at which the children were made subject of child protection plans under the category of neglect.

A review child protection conference was held deciding that the children should remain subject of child protection plans. Core groups (responsible for developing the child protection plan) were held regularly.

Advice was provided to mother and her partners about the risks associated with co-sleeping.

AN09 died whilst co-sleeping with his mother, his sibling and his mother's partner. AN09's sibling was admitted to hospital and then placed, with mother's agreement, with foster parents. He is now the subject of care proceedings.

6 Learning Points and Recommendations

The IMRs identified learning points and recommendations for their own agency. Action plans, stating how the recommendations will be implemented, have been created by each agency and were submitted to NSCB along with the overview report.

6.1 Learning Points

This case illustrates the vulnerability of infants, especially when born prematurely and to carers who are themselves vulnerable and have many health and/or social problems – principally alcohol misuse in this case but also domestic violence, poor mental health and unstable lifestyles. It also illustrates the importance of vulnerable parents making positive use of services to ensure the children receive proper care. Assessments need to establish whether parents have the motivation and capacity to provide an acceptable standard of care within a timeframe that will support the development and welfare of children. They also need to address whether and how partners make a positive or negative contribution to the care of children.

The review identified some good practice, including a number of safeguarding actions such as: the holding of a hospital discharge meeting; the decision to initiate a child protection enquiry and convene an initial child protection conference; the children being subject of child protection plans; the warnings to mother not to sleep in a bed with AN09 and his sibling; the integrated professional actions following AN09's death.

The children could have been better safeguarded had for example: the health network acted more swiftly and in unison upon becoming aware of mother's pregnancy; a pre-birth core assessment been undertaken; full background information been gathered and considered; more child-focussed and evidence-based assessments been conducted; there had been better attendance at conferences and core groups; better plans been constructed.

Whether better practice would have led to a different outcome is a matter of conjecture. It may have led the network to conclude that mother was not sufficiently motivated or able to change within a reasonable timeframe and thus persuaded the local authority to instigate care proceedings, though it is unclear whether the

threshold for removal of AN09 and his sibling would have been met. The overview report concluded that that it is not possible to say with any certainty that the death of AN09 could have been prevented but that there were lessons to be learned that may have led to a different outcome for him.

The overview report identified the following learning points:

1. Agencies should make timely, planned and integrated assessments of the potential risk to the unborn child and, where that assessment indicates the child may suffer significant harm, refer the matter swiftly to Children's Services.
2. Agencies should refer their safeguarding concerns in a timely manner to social care by telephone followed by a written confirmation of the concerns. (The NSCB procedures have been revised to address this, stipulating a timeframe by which the referrer should make telephone contact if no confirmation of the referral has been received.)
3. Agencies should respond to parental non-compliance as a significant risk factor and consider an escalation of the level of intervention.
4. On receipt of a referral suggesting significant harm to an unborn child Children's Services should assess risk under the aegis of a core assessment and, as one aspect of this, consult with involved agencies as to the appropriateness of an initial child protection conference.
5. Where there are concerns of risk to an unborn child agencies should make contingency plans in the event of premature delivery. (The NSCB procedures have been revised to address this).
6. The discharge from hospital of infants about whom there are safeguarding concerns should establish whether this can be undertaken safely. A discharge plan should be made and sent to all involved agencies. (The NSCB procedures have been revised to address this.)
7. Written agreements should be made with parents to strengthen child protection plans and make expectations explicit to them.
8. Children's Services should establish the history of all carers; this to include the reading of case files where there is information germane to the safety of the children.
9. Strategy discussions should involve at the very least Children's Services and the police.
10. Professionals should be invited to child protection conferences if they have a significant contribution to make, should attend and provide a written report.
11. Core groups should develop the outline plan, making due amendments in response to new information or developments. They should promote an understanding amongst agencies and carers as to expectations of the latter. They should be attended by those agencies which can contribute positively to these functions.
12. Assessments (core/joint) should be planned so that key areas to be pursued, timeframes, recording etc are clear from the outset.
13. Where there are substance abuse issues the assessment should be conducted against the *Drug and Alcohol Using Parents* practice guidance. Where there are constraints upon professional understanding (e.g. no reliable objective test) assessments should explicitly address that constraint and not conflate self-report and fact.
14. Managers and chairs of child protection conferences should ensure that assessments are conducted as planned.
15. Allegations of significant harm to children should be enquired into, irrespective of the source of the allegation or the inferred motive.
16. Where co-sleeping is specified within a child protection plan, the plan should specify how this is to be monitored and the implications of non-adherence.

6.2 Recommendations

The IMRs prepared for this review contained a range of recommendations covering the learning points identified above. All of these recommendations were endorsed by the overview report author.

In addition the overview report made the following recommendations to NSCB.

Recommendation 1: In respect of *Drug and Alcohol Using Parents* NSCB should ask all constituent agencies to report how they will ensure staff make use of this guidance and how they will monitor its usage.

Timeframe: Agencies to report back in three months

Recommendation 2: Child protection conference chairs should be asked to incorporate the use of *Drug and Alcohol Using Parents* guidance into outline child protection plans as appropriate

Timeframe: Child protection conference chairs to implement within one month.

Recommendation 3: In respect of child protection conferences NSCB should monitor attendance and the submission of reports and take action where there are deficits.

Timeframe: Establish method for monitoring/taking action within one month. Report back to NSCB in a further six months.

Recommendation 4: NSCB should develop inter-agency guidance on core groups.

Timeframe: Establish means of developing guidance in one month. Produce guidance within a further six months.

Recommendation 5: In respect of core (or joint) assessments NSCB should establish what barriers exist to these being undertaken to a high standard and take steps to counter the barriers.

Timeframe: Establish how research is to be conducted in two months. Research to be undertaken and reported back to NSCB within a further six months.

Recommendation 6: NSCB should consider how it can promote *Reduce the Risk of Cot Death Guidelines* to those parents who are least likely to heed them.

Timeframe: To be considered within the Child Death Overview Panel by February 2010.

Recommendation 7: The learning in respect of both risk to vulnerable children and professional interventions should be incorporated, as appropriate, into the training programmes of NSCB and constituent agencies.

Timeframe: To report back to NSCB in six months.

Recommendation 8: NSCB should ensure that child protection plans are strengthened, as appropriate, by the use of written agreements with parents.

Timeframe: NSCB to promote use of written agreements within one month.

The overview report endorsed two recommendations suggested by the NHS Nottinghamshire County and Sherwood Forest Hospitals NHS Trust for the agencies concerned:

To Nottinghamshire Children and Young People's Services**: NCYPS should review its information-sharing processes to ensure that minutes of all meetings and plans are sent in a timely manner to involved agencies (this to include both hospitals where a child is transferred).**

To NHS Nottinghamshire County and Sherwood Forest Hospitals NHS Trust: **The primary care trust should, together with the SFHT, review how the paediatric health visitor service records and shares information.**

All the above recommendations were accepted by NSCB and have been incorporated into a multi-agency action plan. This plan has been endorsed, and will be monitored by NSCB via the Standing Serious Case Review Panel, which will provide regular feedback to the Board on progress against the action plan.

7 Ofsted Evaluation

The Ofsted evaluation of this serious case review was received in June 2010, it was judged to be good.