



SERIOUS CASE REVIEW Executive Summary

**RELATING TO JOHN
ETHNIC ORIGIN: WHITE BRITISH**

Published March 2009

1. Introduction

- 1.1 Serious Case Reviews are carried out by Nottinghamshire Safeguarding Children Board (NSCB) in accordance with government guidance set out in Chapter 8 of Working Together to Safeguard Children, published in 2006.
- 1.2 John was an 11mth old White British child who was injured by his Mother in late 2007. It should be noted that John is not his real name but used to anonymise this summary report. Serious Case Reviews are required to be carried out when a child has died or has been seriously injured and abuse or neglect are known or suspected to be a factor. In this case John was not seriously injured, however it was clear that there were lessons to be learnt from the case about the way agencies had worked together so it was agreed a review should be conducted.
- 1.3 In this case all agencies that had had contact with John or his family provided management review reports on their agency's involvement. The NSCB established a Serious Case Reference Group [SCRG] to oversee the case review process and appointed an Independent author to prepare the Overview report itself. The Overview Report was written by an experienced professional wholly independent of any of the agencies involved with the case. The Author worked closely with SCRG to ensure all lessons were learned through this process.
- 1.4 The following agencies contributed to this review:
 - Nottinghamshire Children and Young People's Service – Children's Social Care
 - Nottinghamshire Healthcare NHS Trust
 - Nottingham University Hospitals NHS Trust
 - Nottinghamshire County NHS Teaching Primary Care Trust
 - Borough Council (Housing Benefits)
 - Connexions, Nottinghamshire
 - Nottinghamshire Probation
 - Nottinghamshire Police
 - CAF/CASS (Court Advisory and Support Service)
 - Spirita Housing Association
 - Floating Support at Metropolitan Support Trust

2 Terms of reference:

2.1 The terms of reference for this review were drawn up by the serious case review group and included the following specific areas for consideration by the review:

- The assessment of parenting capacity immediately prior to and following the birth of John, including whether this adequately took into account the history of John's mother's mental health problems and the previous assessment regarding the care of John's older half-sibling.
- The quality of inter agency work, whether this addressed developing concerns relating to John's mother's mental health, substance misuse and domestic violence.
- Whether appropriate use was made of the existing child protection framework in relation to the above issues and in responding to unexplained injuries.
- Whether appropriate services were provided to meet the identified needs of John and his family.

3 Family Member Involvement

3.1 In line with Government guidance, both parents and members of the extended Family were contacted by the Independent author as part of this serious case review. Their comments were taken into account in the conclusions reached by the review.

4 Case Summary

4.1 In late 2007, an incident occurred during which John was allegedly assaulted by his mother. John was taken to the Queen's Medical Centre in Nottingham where he was found to have bruises and abrasions to his face and various parts of his body. Fortunately the injuries were not life threatening and John made a full recovery.

- 4.2 John was looked after by his Mother who was his main carer. However John had frequent contact from his Father at the family home though the extent of this relationship was not fully understood.
- 4.3 Prior to the birth of John there had been a range of concerns identified relating to his mothers parenting abilities. These included her poor mental health and a history of drug and alcohol misuse. These difficulties had previously impacted on her parenting to the extent that an earlier child (of a different Father), born 5yrs previously, was removed. Although concerns (including relating to domestic violence) had been recognised prior to the birth of John, and a multi-agency pre birth meeting planned, John was, in the event, born prematurely and before the planned meeting.
- 4.4 Shortly after John's birth, a multi agency plan was agreed which provided monitoring and support to the family, principally by health professionals and the extended family. However, concerns escalated when John's mother's mental health appeared to deteriorate and a number of incidents of domestic violence (involving both parents) occurred at the family home in John's presence. The professionals involved were finding it increasingly difficult to gain access to John to monitor his progress and although his physical presentation appeared satisfactory, concerns about his welfare grew, including unexplained bruising.
- 4.5 Multi- Agency work with the family continued up until the incident.

5 Lessons Learnt

- 5.1 John was the subject of a multi agency plan and there was continuous support to his mother, particularly from the mental health services, prior to and following his birth. However, it has been acknowledged that a more thorough assessment of his Mother's ability to provide appropriate care to her son should have occurred. This did not take place until after the incident that led to this review. Alongside this there appeared to be a lack of understanding or assessment of the role and impact of John's Father within the household. Although he was a frequent visitor to the household, particularly in the early months of John's life, the extent of his involvement was not explored and work was directed through John's Mother. Assessments in circumstances such as this

must include both parents, whether permanent members of the household or not.

- 5.2 Given the history relating to John's older half sibling and the mother's continuing mental ill health at the time of her pregnancy, a pre-birth referral to Children's Social Care should have been made as soon as the pregnancy was known about. A thorough pre-birth assessment led by Children's Social Care could then have been carried out to ensure that the duties of all the agencies to safeguard and promote John's welfare could be appropriately discharged. In this case a referral was made to Children's Social Care in the month before the expected birth. However John was born prematurely meaning a planned meeting was held after his birth.
- 5.3 Whilst those involved in supporting the mother in her care of John were sensitive to the needs of the child and there were examples of good inter agency working during the period under review, the provision of services did not take place within a child protection framework and this appeared to impact on the effectiveness of the plan.
- 5.4 There were incidents which occurred between John's birth and the incident leading to this review where child protection procedures should have been instigated but were not. This included one incident of unexplained bruising that was not investigated and therefore not known about by all the agencies involved.
- 5.5 Because John's physical presentation (in the main) and developmental progress appeared to be satisfactory during this period, the professionals involved faced a dilemma because the child appeared well cared for despite the concerns about the adults involved in his life.
- 5.6 Had the child protection framework been used appropriately, it is likely that there would have been a multi agency child protection plan in place with a clear focus on addressing the risks to the child. In addition the plan would have included a contingency plan setting out the actions required to safeguard the child if the primary plan was not successful.

6 Recommendations

6.1 A range of recommendations have been made by the agencies contributing to this review covering the following:

- The training of staff in relation to safeguarding children where there are issues of parental mental ill health and/or substance misuse
- Improvements in communication between and within agencies in relation to safeguarding children
- Improvements in practice when carrying out assessments to ensure that the full extent of the family's background history is taken into account
- Improvements in practice where parents fail to engage with services which are being provided to promote the welfare of their children
- The expectation that Children's Social Care will carry out a Core Assessment in relation to a child newly arrived in a household (including an unborn child) where a previous child has been removed because of concerns about significant harm.

6.2 The independent author of the overview report made additional recommendations as follows:

1. It should be made clear in the NSCB Inter Agency Procedures that the definition of "child" includes an unborn child.
2. There should be a separate section on pre-birth referrals in the NSCB's Inter Agency Procedures and it should be made clear within this section that a referral should be made as soon as any agency becomes aware that a person who has previously had a child removed (or their partner) has become pregnant or assumed the care of another child.
3. Review, and revise as appropriate, current Inter Agency Procedures in relation to the discharge from hospital of children about whom there are safeguarding concerns, to reflect the needs of children being discharged following birth. This should be clearly cross referenced within the revised pre birth section proposed at recommendation 2 above.
4. Where a medical assessment takes place as part of a Section 47 Enquiry there should be a requirement for

the paediatrician to provide a written summary report immediately, at the end of the medical assessment, to those attending and a full report within 72 hours.

5. At any inter agency meetings held which concern children, the chair of the meeting should make it clear to participants what the purpose of the meeting is, under which procedure it has been convened and how the outcomes agreed at the meeting are going to be circulated.
6. It should be made clear within the NSCB Inter Agency Procedures that any plan in relation to a child, or adult who is a parent or carer, should include a contingency as to what should happen in the event of the non-engagement of one of the parties to ensure that any resultant safeguarding concerns are addressed.

The NSCB considered the outcome from the review at a meeting in July 2008 and accepted the findings and all of the recommendations. The NSCB will monitor their implementation through Action Plans to ensure that the lessons learnt from this Review are acted upon appropriately.