Child J

Serious Case REVIEW REPORT

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1. Introduction

1.1 This Serious Case Review (SCR) is in respect of a child to be known as Child J[1].

1.2 The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children. Learning is relevant locally, but it has a wider importance for all practitioners working with children and families and for the government and policymakers. Understanding whether there are systemic issues, and whether and how policy and practice need to change, is critical to the system being dynamic and self-improving. Reviews should seek to prevent or reduce the risk of recurrence of similar incidents. They are not conducted to hold individuals, organisations or agencies to account.[2]

1.3 The circumstances of this case were initially considered by the KSCB Case Review Group in June 2015. At the time, the Case Review Group agreed that the case did not meet the criteria for a SCR. Although the family had vulnerabilities and Child J had received injuries, it was felt that agencies could identify improvements to practice. It was therefore agreed that KSCB would undertake a Local Case Review. This review included the obtaining of agency reports and participation of practitioners in a Learning Event.

1.4 The Review concluded in January 2016 and, although not published, learning identified was disseminated to the relevant staff and agencies.

1.5 Following further information of the seriousness of the life changing injuries to Child J coming to light during the subsequent criminal trial, the KSCB Independent Chair, made the decision that a SCR should be undertaken, as she was of the view that the injuries sustained constituted serious harm, as per the Working Together 2015 SCR criteria.

1.6 As a Local Case Review was undertaken in 2016, it was agreed that the initial Review Report of January 2016 be reviewed, and relevant and proportionate work be undertaken to elevate this report to a full SCR.

1.7 Agencies which worked directly with Child J's family were asked to review their agency report from the Local Case Review and report on any additional information provided on areas identified as in need of greater focus, any actions taken to date as a result of the Agency Review and any recommendations and learning.

1.8 It was agreed that the scope of the Review would be the period from January 2014 up to November 2014, the date of the incident when Child J was admitted to hospital.

2. Background to the Case

2.1 In November 2014, when Child J was 5 weeks old, he was taken to the GP Practice by his mother. Both the GP and Practice Nurse identified Child J as being seriously unwell and called

[1] In order to provide protection of the families identify, a pseudonym is being used.

[2] Working Together to Safeguard Children, A guide to inter-agency working to safeguard and promote the welfare of children - July 2018

an ambulance through a 999 call and Child J was taken to their local hospital and subsequently moved to a London Hospital Paediatric Intensive Care Unit.

2.2 Child J lived with his mother and father. He was their first child, his mother was 21 years and father 44 years old when Child J was born. The parents lived in social housing at the time of Child J's birth. Neither parent was employed at the time.

2.3 Mother had booked late for midwifery services (22+ weeks[3]).

2.4 Father was a known drug user, reported as being on a Heroin Replacement Therapy Programme, had a mental health history of depression and reported that he came from a traveller family[4].

2.5 Following a delayed decision to initiate criminal proceedings, the parents were convicted at court and received custodial sentences.

2.6 Specialist Children's Services (SCS), now known as Children's Social Work Services, undertook a children and family's assessment[5] in August 2014 and completed it in October 2014. A 12-week parenting assessment was planned, however, this did not happen as Child J was admitted to Hospital 2 days later.

3. Family Structure

3.1 The relevant family members in this Review are Child J and his birth mother and father. There was no evidence in any of the reports submitted by agencies involved with the family that any issues of race, religion, language or culture affected events in this case.

4. Scope of the Review

4.1 The scope of the review was agreed to be from January 2014 to November 2014; the time when periods of intervention that are judged to be significant to understanding the work undertaken with Child J and his family. The interventions are key from a practice perspective, rather than to the history of the child. They do not form a complete history of the case, but summarise the relevant activities that occurred and include the information that is thought to be most helpful in informing the Review.

[3] NHS national guidance is that a woman should book her first Midwifery appointment at 10 weeks in order to obtain the information she needs to have a healthy pregnancy.

[4] Travelers are distinct groupings of wandering people who are generally considered as nomadic societies that travel from one place to another.

[5] The purpose of the assessment is to gather sufficient information about the child and family to understand its needs and make decisions about: The nature and impact of the concerns or needs described in the referral and what intervention or support is necessary; Whether the child meets the criteria for ongoing services as a 'Child in Need'.

5. Background prior to the scoped period

5.1 Father was reported as having had a number of criminal convictions from 1990. The majority for theft offences. There is one recorded conviction in 2000 for a domestic violence assault against his then partner.

5.2 Police reported that father disclosed that, due to a difficult childhood, he turned to drugs aged 14 years. His life was driven by his drug habit and any criminality was linked to his drug taking.

5.3 There was limited background information in regard to mother. She had disclosed to the Health Visitor that she had a difficult upbringing and only expanded further on this by referring to being bullied at school. The was also an earlier GP report of her suffering from depression, but there was no record that any medication was prescribed.

6. Key Events – January 2014 to October 2014

6.1 In February 2014, both mother and father were arrested by Kent Police in relation to drug offences. On return to the Police Station on bail two months later, mother reported to the Custody Officer that she may be pregnant with her boyfriend's baby.

6.2 Father registered with a local GP Practice and saw the GP due to depression following the death of a family member. The GP prescribed an antidepressant, however, father did not attend for follow up review. Father also reported to the GP at the time, his history of drug taking and that he was not currently attending his drug recovery sessions. The GP provided a prescription for substitutes.

6.3 Mother registered with the local GP and Midwife in May 2014. Mother was seen by the GP in June, and the GP records show that mother was 22 weeks pregnant at this time. A pregnancy assessment was undertaken by the GP. Mother at the time, could not confirm why she had booked in late for Midwifery services. Ante-natal appointments were booked. A family background questionnaire was completed by the Midwife; this did not indicate any on-going high risk history. However, due to father's background, it was agreed that a Concern and Vulnerability Form would be completed, with a referral to SCS Central Referral Team. This referral was in accordance with Midwifery policy relating to risk factors, such as a substance using parent or a parent with mental health concerns. Along with the referral to SCS, the GP, Health Visitor and Community Midwifery services were also notified.

6.4 SCS District Social Work Team did not receive the referral until August 2014, following an unexplained three month delay. The case was then allocated to a duty Social Worker for an assessment to be completed. All agencies were included in this process, including the Drugs Services working with father. Father was assessed as being anxious about professional involvement, but he engaged well. Mother was noted to be quite timid and did not seem to share information in the way father. Father was open about his historic drug use and having a police record. The family remained engaged during the Child and Family Assessment process.

6.5 Once the Health Visitor received the Concern and Vulnerability Form, she attempted to book a visit with mother prior to the birth of Child J. She initially found it difficult to book an appointment due to a number of incorrect numbers being provided by mother, (it is not

known if this was deliberate or accidental), but once she had made contact, the Health Visitor started to complete the Family Health Needs Assessment[6].

6.6 Father disclosed his full history to the Health Visitor. She read through the assessment with the parents to ensure they both understood, particularly as father disclosed that he has dyslexia. Mother stated that she supported father with reading and writing. Mother referred to a difficult upbringing, and gave an example of being bullied at school. This was not explored any further.

6.7 The Health Visitor noted that the flat was cluttered, but it was not an unsafe environment for a baby. It was felt that the parents were preparing the home for the baby's arrival. Father initially voiced concerns about being worried about another professional becoming involved, but listened to the role of the Health Visitor and accepted this. Mother reported that maternal grandmother lived nearby and would be supportive.

6.8 During the scoped review period, Housing Officers reported that tenancy visits and audits were undertaken. The property was described by Housing Staff as cluttered. Cleaners observed that there was drug use on the same floor as the home of mother and father. On one visit, a Housing Worker observed possible injection sites on father's arms. A number of people were observed entering the property. This information was not shared with any other professionals at the time.

7. Key Events –October 2014 to November 2014

7.1 On 8th October 2014, Child J was born at home at 39 weeks gestation (although mother had planned a Hospital birth) and conveyed to the local maternity unit by ambulance. This is standard practice. It was reported that mother and baby were doing well.

7.2 Following the birth, the Health Visitor informed Social Services of the birth and the Social Worker reported that they have no role within the family due to no specific risks to the baby being identified, however, due to the number of professionals involved, it would be appropriate to convene a Child in Need[7] meeting so that everyone was working together, and that a parenting assessment would be undertaken. This was in line with KSCB procedures.

7.3 Midwifery services provided 28 days extended services, (within statutory responsibilities), during which the parents were observed to have all appropriate equipment for Child J, mother was breastfeeding well, basic needs were provided for and signposting to other services for additional support was given. Mother failed to keep a post-natal and six week baby check with the GP in October 2014.

7.4 At the next the Health Visitor home visit, she observed father to be gentle with his son, both parents gave good eye contact to Child J and both engaged well with him. The family were

[6] A health assessment that explores the many areas of daily life can affect the health of a mother and father and their families. This assessment enables services to identify any areas where the family could benefit from additional help and support.

[7] A Child in Need Meeting is a multi-agency meeting led and coordinated by a qualified social worker to provide a rigorous analysis of the child's needs and the capacity of the child's parents to meet these needs within their family and environment.

offered enhanced health visiting services[8] due to the family's vulnerabilities being identified in the health needs assessment.

7.5 A Social Worker who visited following the birth, equally found no concerns for Child J's social presentation, there was good interaction between mother and child, and parents had prepared well for the baby. The Social Worker referred the parents to the local Children's Centre[9] for additional support.

7.6 As planned, a Children In Need meeting was held on 5th November, attended by a number of professionals and the parents. It was agreed that a parenting assessment would be undertaken, and the case was transferred appropriately to the Family Support Team.

7.7 On the 18th November, Child J was taken to the GP Practice by his mother. Both the GP and Practice Nurse identified Child J as being seriously unwell and called an ambulance. He was taken to the local Hospital Emergency Department (ED). He was assessed as requiring intensive care and was retrieved to the Paediatric Intensive Care Unit at a London Hospital.

7.8 It was established that Child J had a number of injuries all of which were consistent with a non-accidental injury/trauma. Specialist Children's Services and Police were notified, and child protection procedures instigated.

8. Practitioners' Learning Event

8.1 The Practitioner Focussed Learning event held during the initial learning review was attended by a number of agencies, including, children's social care, midwifery, health visiting, General Practitioner, NHS specialist safeguarding professionals, housing, ambulance, police and KSCB.

8.2 The mix of frontline practitioners and managers/team leaders enabled open discussion, built in constructive challenge and an appreciation of different roles and responsibilities. It also provided a forum for learning together and agreeing actions to take forward to improve services in the future.

8.3 The event gave professionals the opportunity to reflect and learn from what happened, to identify key issues, review decision making, the effectiveness of organisations in addressing risks and identify improvements for the future. Conclusions at the time recognised that there were risks and vulnerabilities within the family, particularly those associated with father's drug use and episodes of offending behaviour.

8.4 Professionals had a generally positive picture of the family and care given to Child J and there was no evidence provided that could have predicted that Child J would result in sustaining serious non-accidental injuries.

[8] Additional visits within the Healthy Child programme for families with vulnerabilities or requiring additional support.

[9] Children's Centres provide a range of integrated services to meet the needs of the community they serve. They also have a role to play in bringing together all professionals who work in the area; to learn from each other's expertise; and provide integrated support and extra help as required to families.

9. Key learning themes

9.1 From information gained from this review, the following key themes emerged:

- Pre-birth Planning and Assessments
- Professionals' meetings, information sharing and parental engagement
- Parental Drug Misuse

10. Pre-birth planning and assessments

10.1 This was a first-time young mother and it was crucial to explore what support was available to the parents and factor in her support network into any safety planning. The father of Child J is 22 years older than the mother and this could have been an area of focus during the assessment.

10.2 Father was much more open than mother and discussed his long term substance misuse and mental health, however, there was no full exploration of father's own life experiences and history. Understanding parental history is vital in informing assessments of vulnerability and risk and to inform plans.

10.3 Where risk factors are known or identified which may impact on the unborn baby or the child's safety and development, a pre-birth assessment is required. The pre- birth assessment must consider the parents' own history and any vulnerabilities that impact on the child. There was no evidence that a pre-birth assessment was planned or undertaken. This issue is being monitored through a recommendation from a previously published KSCB Serious Case Review, Child E, published in 2017.

10.4 In addition, little was known about the wider family, partly because mother was not keen to provide information, but also because it was not adequately pursued by professionals.

10.5 Following the birth of Child J, it was agreed to hold a Child In Need meeting to agree whether early help services would benefit the family.

10.6 At the Child In Need Meeting, all professionals who attended agreed that a Parenting Assessment would be completed. Both parents attended the meeting and signed up to undertaking a 12 week parenting assessment.

10.7 The parenting assessment did not happen due to Child J being admitted to hospital.

10.8 Learning

10.9 It is important that obtaining family history is given sufficient prominence by all agencies to enable the identification of relevant issues and/or concerns, particularly parents who may be less open with professionals and who may not fully share their family history.

10.10 Where one parent is the more vocal or has specific risk issues, the other parent can be lost in the process of assessment and intervention. Less was known in this case about mother, and it raised professionals to view this as an area for focus in future assessments if it has not been possible to present a balanced understanding of both parents involved.

10.11 Service Changes

10.12 KSCB have developed a pre-birth assessment tool drawing extensively on the work of Martin C Calder.[10] Professionals are encouraged to use the tool along with KSCB Child and Family Assessment.

11. Professionals meetings, information sharing and parental engagement

11.1 At the Practitioners' Learning Event, professionals felt that the culture at the time was that they were not encouraged to hold multi-agency meetings to discuss individual children without families being present, due to the importance of being transparent. Professional meetings allow the sharing of information as this is central in understanding the wider family dynamics and the issues they may be experiencing.

11.2 However, all single agency decisions were taken in the context of routine assessment processes. The professional decision-making was generally in accordance with procedural guidance and evidence-based professional practice.

11.3 Individual professionals/agencies held different information that could have informed the Child and Family Assessment and the Child In Need meeting. For example, Housing Officers and the Ambulance Service observed behaviours, relationships and the social context within the community that the family lived and that the family were living in an environment that could have posed risks to a young baby. When organising professionals meetings or statutory meetings, these should include a wider selection of contributors and where professionals are unable to participate, minutes and actions should be circulated to ensure that all information is shared, and relevant actions undertaken.

11.4 It was good practice that the Midwife and Health Visitor shared information frequently with each other from their service perspective and then passed on information about actions taken to SCS, however, there was limited evidence of any discussions by either the Midwife or Health Visitor with the GP.

11.5 Engagement by father in the plans and giving of information was generalised and partial, and appeared to give the appearance of full engagement. Mother was only seen on 2 occasions without father being present. It is good practice for professionals to meet with both parents individually when working with a family.

11.6 In this case, father was very plausible and perhaps showed a degree of disguised compliance[11]. Partial compliance, as in this case, can result in professionals feeling optimistic and a belief that the parent is engaged in the plan and was able to care for the child. The optimism felt at various stages needed to be balanced against the evidence and on-going risks.

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[10] 'Unborn Children: A Framework for Assessment and Intervention' in Assessment in Child Care, Using and Developing Frameworks for Practice (Russell House Publishing 2003).

[11] Disguised compliance is described as 'Parent giving the appearance of cooperating with the child welfare to avoid raising suspicion, to allay professional concerns and ultimately to diffuse intervention. This can result in p rofessionals missing opportunities to make interventions, remove focus from the child and over optimism abo ut progress.

11.7 Learning

11.8 There was no single agency or cross agency chronology[12] of events undertaken; this prevented collective information being fully analysed.

11.9 Professionals need to be curious about information held by other agencies and proactive in sharing information that may improve the understanding of any risks posed for the child.

11.10 It is also important to encourage professionals to take time to review all available information to support their professional judgements and decision making. It is recognised that this can pose a challenge when professionals have heavy caseloads and limited time available.

11.11 Professionals must maintain a 'healthy scepticism' and 'respectful uncertainty' in order to see beyond what is often being presented by parents. It requires skill and experience to keep a healthy scepticism regarding parents, while still building and maintaining a trusting relationship.

11.12 Service Changes

11.13 Social Workers now complete chronologies for every case. This is being monitored through a recommendation from previously published KSCB SCRs (Child C, published in 2017 and Child D, published in 2018).

11.14 Professionals are now encouraged to hold multi-agency professionals' meeting, however, there is inconsistency across Kent.

11.15 District Council Housing Teams now work closely with the local Community Safety Units.

12. Parental Drug Misuse

12.1 It is well recognised that the misuse of drugs can have an adverse impact on parenting capacity. The links between the misuse of drugs and neglect are strong, as is denial, chaotic lifestyle, manipulation of professionals and involvement in criminal activity.

12.2 Father reported that he was participating in a recovery programme and taking prescribed substitutes. However, when the Community Midwife rang a drug services worker, it was reported that father was no longer engaging in the programme. There was no evidence that the Midwife challenged father about this.

12.3 Father had on one occasion disclosed to the Health Visitor that he had relapsed following the death of a relative, and on one occasion when he was late picking up his prescription. Father's lack of engagement and compliance with the drug dependency recovery sessions is well documented in the GP records. However, there appeared to be several periods of relative

[12] The arrangement of events and dates in order of occurrence, that professionals can use to help them understand what is happening in the life of a child or adult. It is not a risk assessment, but a tool to draw together important information and assist understanding, highlighting early indications of emerging patterns of concern. (Practice Guide to Chronologies- Care Inspectorate Scotland 2010)

stability where father engaged with the recovery services, but also times when his illicit drugs use relapsed, most notably leading up the birth of Child J. There are also several instances within the medical record reflecting the initiation or restarting of anti-depressant medication, and one where father is specifically noted to have failed to attend for review.

12.4 There was no evidence that a risk assessment was undertaken in regard to father's drug use. There are a number of substance misuse risk assessment models available for professionals to use, such as DUST (Drug Use Screening Tool), which if used in this case, could have enabled a fuller risk assessment of the drug misuse, identify the possible impact on Child J, and ultimately whether father was able to function as a parent in the medium to long term.

12.5 Learning

12.6 A parent who self-reports their drug taking must be viewed with respectful caution.

13. Additional Service Changes

13.1 Since 2014, there have been significant changes in the way the Police deal with female detainees, and those that are pregnant. The changes have resulted from learning from a number of incidents, both locally and nationally. The changes include a Forensic Healthcare Professional being asked to speak to any detainee who discloses they are pregnant. The professionals working in custody suites have a remit to screen all detainees for vulnerability, and this would include pregnancy. All female detainees are now also offered a named 'chaperone' whilst in custody. These changes are designed to encourage detainees to disclose any vulnerability, and have resources available to have immediate conversations with the detainee and arrange for the necessary interventions. In 2017, the entire Kent Police operating model was changed to focus on vulnerability.

14. Family engagement

14.1 Family engagement is required as part of the undertaking of a SCR. KSCB notified both birth mother and birth father of the SCR and they were invited to contribute.

14.2 Mother did not wish to be involved.

14.3 Father agreed to discuss his experience of services with the Lead Reviewer.

14.4 Father was open with regards to his drug history and earlier life, however, he felt that some professionals held this against him in their views as to his capability to care for a baby. This made father and mother very defensive and stopped them from talking.

14.5 Child J was a planned baby, and both father and mother were really looking forward to having him. They worked hard to get the flat ready for his birth.

14.6 He stated that help was offered, but sometimes, such as the offer of parenting classes, the help did not always happen. Also, he felt that he and his partner were not always given enough information to help them prepare, although some leaflets were given.

14.7 He did say that, at some home visits after the birth, professionals felt pleased with how well he and his partner were doing.

15. Conclusion and Recommendations

15.1 There is currently no evidence that professionals in direct contact with the family missed signs of abuse to Child J. It was only following the criminal trial that the full extent of the injuries and their impact on Child J was realised and made known to the LSCB.

15.2 Several agencies were involved in the case and sought to work to ensure the safety of Child J.

15.3 Partner agencies of the KSCB and those individuals working with the family have taken responsibility for this case are prepared to learn lessons from this SCR, and have already taken on the findings from the earlier local review, such as Signs of Safety, housing working with the Community Safety Team, holding multi-agency professionals meetings, the Police focus on vulnerable people and SCS now have systems now in place to ensure that a case transfers between teams in a timely manner.

15.4 KSCB have recently had a number of SCRs involving a young parent, and the themes from this and other reviews are being shared with agencies.

15.5 Father believes the following learning could be helpful to professionals following his experience:

- Professionals do what they say they will do.
- Give more support to first time parents, perhaps with more group sessions to discuss things.
- The parenting classes would have been really helpful if they had gone ahead.

15.6 The recommendations made below are intended to add value to the single agency recommendations and are linked to the learning established in this review.

Recommendation 1:

In order to establish a consistent approach, where professionals' meetings are being held, KSCB must seek evidence as to why and when the meetings are convened, and the impact that they have on the case.

Recommendation 2:

There is a recurring theme from a number of SCRs where assessments are not including all family members and/or their history, KSCB are to explore why this is a recurring themes and what can be done to address it