Executive Summary: Serious Case Review - Child D

1. Introduction

This is the Executive Summary of a Serious Case Review (SCR) undertaken by Somerset Local Safeguarding Children Board (LSCB). The review considered the circumstances regarding the serious injuries inflicted upon Child D, at approximately 13 month of age.

The review looked at issues and events dating from nine months before Child D's birth until the diagnosis of the injuries.

This summary includes:

- A description of the review process, including contributors to the review
- A summary of the circumstances leading to the review
- Key themes and lessons for the future
- Recommendations for further action

2. The review process

- A meeting was held on 16 November 2007 to consider whether to undertake a Serious Case Review using the criteria described in Working Together 2006.. The meeting concluded that the criteria were not completely met but there were significant questions that needed addressing to clarify if risk of harm to Child D could have been recognised by any organisation working with the family. The decision was to complete a SCR.
- The overall objectives of the SCR were as follows; to establish a factual chronology of actions taken, to assess whether decisions and actions taken were in line with the policy and procedure of agencies, to consider what services were provided in relation to the decisions and actions and to recommend appropriate action in light of the review's findings.
- A Serious Case Review panel was convened and was comprised of senior managers from the key agencies where that officer had no previous involvement in the case. The Panel included the Independent Overview Report author.
- Agencies that had been involved in the case of Child D, or that had worked with the parents, were asked to complete Internal Management Reviews (IMRs) and to provide appropriate chronologies of their involvement.

3. Contributions to the review

The following organisations provided individual agency IMRs:

- Somerset Primary Care Trust – who provided Primary Care for Child D and the parents

- Avon and Somerset Constabulary – who had historical information about Child D's parents and were involved in the investigation of circumstances concerning the injuries
- A Somerset Hospital NHS Foundation Trust – which provided ante-natal care to Child D's mother and where Child D was born
- A Bristol Health Trust – which provided medical care for Child D following the diagnosis of significant injury
- A Somerset pre-school setting – where Child D attended
- Somerset Partnership NHS and Social Care Trust – who provided services to Child D's parents and employed members of Child D's family.

4. Terms of Reference

It was agreed by the SCR Overview panel that the review would aim to address to following:

- Do services make adequate ongoing risk assessments (in terms of content and frequency) of clients assessed as "low risk" where they are also parents?
- Is multi-agency risk assessment of parents who misuse substances appropriate in terms of addressing the impact of substance misuse on parenting capacity?
- Are health agency and specialist service thresholds appropriate for referral to Children's Social Care, where parents have known substance misuse issues?
- Are Children's Social Care thresholds appropriate for receiving referrals where parents have drug/alcohol issues?
- Are there cultural issues in relation to nationality that have not been recognised or addressed?
- Did the professional status of various family members adversely affect appropriate information sharing and risk assessment?
- To what extent have specialist services addressed the guidelines and recommendations set out in the DOH response to "Hidden Harm"?

5. Brief summary of the review

Child D's parents and their first child moved to Somerset from the north of England. Both parents, it transpired, were drug users and at various times received services from specialist services for a number of specific issues.

Child D was born in a local hospital, spending four weeks in the Special Care Baby Unit experiencing opiate withdrawal. At thirteen months of age, Child D was taken to the GP by the parents with facial bruising and bruising to the back. The explanation given was that Child D's then three year old sibling had caused the facial bruise with a toy and that Child D had fallen from a sofa to cause the bruising to the back. The GP was immediately concerned about child protection issues and referred the family to the local hospital.

The next day, Child D was transferred to a regional specialist hospital due to a suspected serious internal injury that required surgery. During surgery further internal injuries were found and a later CT scan and skeletal survey showed a vertical skull fracture. A diagnosis of impact injury was made, a diagnosis not compatible with a fall from a sofa.

On conclusion of the review, the analysis noted a number of key issues that can be summarised as follows:

1. **Information sharing.** The level of information sharing between professionals and across agencies was not adequate, including where information needed to be shared within an organisation. There were recording issues raised by issues of confidentiality where one parent and other family members were professionals working within a key agency.

2. **Missed opportunities for referral to Children's Social Care:** There were four key periods identified when it would have been advisable for professionals to refer to Children's Social Care, highlighting key issues mirrored in "Hidden Harm", as published by the "Home Office". This includes specialist medical staff working in the Special Care Baby Unit.

3. **Impact of professional status on confidentiality:** Three family members, including one of Child D's parents, were professionals working in, or known to, the professional network working directly with Child D and the family. This will have affected perceptions of the family and the nature of support provided.

4. **Ethnicity**: One of Child D's parents is of an ethnicity that is not White British. There are no recorded notes detailing consideration of the impact of the ethnicity or exploration of what this meant in terms of the most appropriate support.

5. **Issues for clinical practice:** A number of issues arose including how information is shared where parents are professionals working within the network, recording prescribing histories accurately, impact of substance misuse on parenting and information sharing with the DVLA.

6. Conclusion

On the basis of the SCR report, in summary the Overview Panel responded to the questions set out in the Terms of Reference as follows:

- **Do services make adequate ongoing risk assessments (in terms of content and frequency) of clients assessed as "low risk" where they are also parents?**

There was no evidence of a new risk assessment being completed when the family arrived in Somerset – the previous "low risk" assessment was

adopted. There was no detailed history taken for Child D's mother nor any risk assessment made.

- **Is multi-agency risk assessment of parents who misuse substances appropriate in terms of addressing the impact of substance misuse on parenting capacity?**

No appropriate risk assessment was conducted and there was a multi-agency view that referral to Children's Social Care would not have resulted in a service being provided. The organisations involved should have implemented their duties to safeguard and protect children regardless of the response anticipated from CSC – effectively, the "jigsaw pieces" needed to be shared.

- **Are health agency and specialist service thresholds appropriate for referral to Children's Social Care, where parents have known substance misuse issues?**

The guidelines available at the time did not provide explicit thresholds for referral to Children's Social Care

- **Are Children's Social Care thresholds appropriate for receiving referrals where parents have drug/alcohol issues?**

Within Children's Social Care, thresholds were deemed to be appropriate. However, there was a lack of understanding of, and confidence in, Children's Social Care referral processes and so there needed to be consideration of a wider dissemination of the Eligibility Criteria.

- **Are there cultural issues in relation to nationality that have not been recognised or addressed?**

Child D's parent chose not to discuss the impact of ethnicity at any stage. However, none of the IMRs indicate that such a discussion was attempted by any agency working with the family.

- **Did the professional status of various family members adversely affect appropriate information sharing and risk assessment?**

It appears that professional status affected perceptions of risk on at least one occasion. The professional status of Child D's parent may have influenced other professionals to comply with their wishes, thus supporting a culture of secrecy. There was an impact upon the availability of team support for one of the professionals who was working with one of Child D's parents.

- **To what extent have specialist services addressed the guidelines and recommendations set out in the DOH response to "Hidden Harm"?**

This question remained unanswered by the review but has been thoroughly examined by the LSCB and DAAT.

7. Main recommendations for future action

1. All agencies should have clear procedures in place stating how highly confidential cases are managed. This should include those cases where staff and/or members of their families are involved, as well as other professionals. Procedures should include:

- How supervision arrangements will be managed for the member of staff holding the case.
- Identification of a named person with whom the case holder may talk informally on a day-to-day basis.
- Clear accountability about who should liaise with regulatory bodies should the need arise.

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2. All organisations must ensure that case recording for families where there are children includes specific reference to when a child was seen and by whom, whether or not the parent is the primary client.

3. A multi-agency model of safe working practice for families where either parent misuses substances should be developed to replace the Somerset Multi-agency Guidelines for Working with Substance Misusing Parents.

4. The LSCB should initiate a self-assessment process with all agencies working with substance-misusing parents to identify current service provision and information sharing practices.

5. The LSCB should develop a clear multi-agency understanding about the use of consultation with CSC at an early stage, where uncertainty exists about the appropriateness of referral so that they can be an integral part of the information sharing process.

6. The LSCB should promote access to specific training for all staff that work with children or their parents, where one or both of the parents misuse substances.

7. Specialist drug services in Somerset should take a number of steps:

- Adopt the South West Child Protection Procedures.
- Develop a prioritisation process where substance misusers who have children have significant priority.
- Ensure supervision is available to all staff that reflects the potential risk to these children.
- Provides training, or access to it, for all staff on child protection and the impact of parental substance misuse as set out in Hidden Harm.
- Develop recording procedures that include noting when a child is seen in the course of appointments as part of the adult record.

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