

**ISLE OF WIGHT  
LOCAL SAFEGUARDING CHILDREN BOARD**

**SERIOUS CASE REVIEW  
PUBLICATION OF EXECUTIVE SUMMARY**

**IN RESPECT OF CHILD 1**

## **Introduction**

The Isle of Wight Local Safeguarding Children Board will always undertake a serious case review (SCR) when a child dies, (Including death by suicide) and abuse or neglect is known or suspected to be a factor in the child's death.

Serious case reviews are carried out under the statutory guidance of *Working Together to Safeguard Children* (2006). The purpose of a serious case review is to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together
- Identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children

Serious case reviews are not inquiries into how a child died or who is culpable. That is a matter for the coroners and criminal courts to determine as appropriate.

This executive summary relates to a serious case review undertaken by the Isle of Wight Local Safeguarding Children Board, in respect of the death of a 30 day old baby in August 2007.

The cause of death was recorded as sudden unexpected death in infancy. The report does not re-examine the police enquiries into the child's death, but it should be noted that these enquiries concluded that the child's death was as a tragic unexplained event.

The loss of a child is a tragedy and the Isle of Wight Local Safeguarding Children Board holds the deepest sympathy for the child's parents and family.

## **Summary**

In August 2007 ambulance services were called to a one month old child, who was found unresponsive by the mother at their home address. The child was pronounced dead at the scene by the paramedic team.

The child had been subject to a child protection conference pre-birth being formally entered on the child protection register at birth under the category of neglect. The child's three siblings were placed on the child protection register at the same time under the category of neglect.

As the children were subject to child protection plans when Child 1 died the case was referred to the Local Safeguarding Children Board (LSCB) for consideration of a serious

case review having met criteria 8.6 of “Working Together to Safeguard Children” (2006) – *‘A LSCB should always consider whether to undertake a serious case review ..... where the case gives rise to concerns about the way in which local professionals and services work together to safeguard and promote the welfare of children’*

The report was commissioned by the LSCB on 23.10.07, with a review period from June 2006 to August 2007.

Individual Management Review (IMR) reports were requested from nine agencies known to have had professional involvement. An additional report was commissioned when it became evident that a voluntary support worker (VSW) had received a professional referral and had significant involvement with the family throughout the period of the review.

## **PARENTAL INVOLVEMENT**

The chair of the serious case review (SCR) panel met with the parents to explain the ‘Working Together’ requirement and the process of the review. In a subsequent reconsideration of the review, the parents met with the independent chair and author and contributed their views to the report.

## **TERMS OF REFERENCE**

- To consider interagency working within the processes of assessment of risk with particular reference to environmental factors and their impact on the health and well being of a vulnerable newborn.
- To assess whether the guidance within the Housing Health and Safety Rating System (HHSRS) was followed.
- To establish whether child protection planning and the child protection plan adequately safeguarded an infant known to be at risk of neglect and registered as such on the child protection register, inclusive of the risk of, and parent education for co-sleeping.
- To assess whether interagency planning post delivery adequately assessed the information available about the vulnerability of the newborn.
- To determine whether professional decision making and/or information sharing by any agency placed the infant at risk of harm.
- To determine whether cultural relativism had any role in professional decision

making which led to the adverse outcome for the infant.

- To explore the interdisciplinary circumstances around the resuscitation attempt/ certification of infant death within the context of the multi-agency Hampshire and IOW SUDI protocol and Royal College of Pathologist & Royal College of Paediatrics “Sudden Unexpected Death in Infancy” protocol.
- To identify any lessons which might improve interagency working in the safeguarding of children identified as at risk of neglect and submit a report for consideration of the LSCB with associated recommendations within four calendar months from date of commissioning.
- To highlight ways in which practice can be improved and make recommendations as appropriate.

## **PROFESSIONAL INVOLVEMENT**

In exploring the life experience of the children reference was made to the research by Reder, Duncan and others which seeks to explain why fully qualified and experienced professionals become lulled into a false sense of security, normalise, collude, fail to recognise disguised compliance and assessment paralysis and thereby are unable to safeguard the vulnerable child and children with whom they have sustained and regular contact.

14 months before Child 1’s death, the family moved to the area. Child 1 was born during this period. The children and family’s presence first became known to a single agency, the education welfare service (EWS) by mainland transfer of information and six weeks later to other universal services by an anonymous referral raising concerns about the health and welfare of the young children.

Following the anonymous referral, children’s social care, health and the police jointly visited the home. This shows effective interagency communication and a shared safeguarding responsibility. However, this appears to have been dissipated by professionals’ acceptance of parental description of appropriate facilities and professionals’ observation and recording of the children being “dirty but not neglected” and “dirty but happy”.

This acceptance of the situation by agencies appears to have “normalised” the children’s environmental conditions, and it formed the bench mark within which professionals

continued to interpret the children's health and wellbeing.

Education and health accepted the role of engaging with the family and children's social care closed the case although there was no evidence of improved conditions.

Drug Action Services (DAS) received a direct referral from mainland services, notifying the drug dependency and methadone replacement needs of both parents within a monitored programme 5 months after their arrival in the area.

Meanwhile allegations of physical violence, damage to property, intimidation and drunken behaviour became a feature of the area where the family lived, but formal proceedings were not pursued by any parties involved.

The children's experiences were not fully explored within the police children and young person (CYP) notification so no service or professional had full knowledge of the children's life experience.

It was considered that parental disguised compliance led some health and education professionals to believe that the family were engaging, despite non prioritisation of the need to register with a general practitioner (GP), delay in medical treatment for a skin infection and the decision to educate an older child out of school (EOTAS) on an unsafe site.

At 28 weeks gestation, 18 weeks into maternity care for Child 1, the supervisor of midwives initiated a professionals' meeting chaired by health to share information and assess the risk to the unborn child and siblings. Information shared during the meeting raised the threshold of concern. This led to the immediate re-engagement of children's social care and a dual agency home visit with Police.

As a result of this visit consideration was given by team managers to immediately safeguard the children within police protection powers, but the decision was reduced to safeguarding within a child protection conference plan as the risks were deemed to be more chronic than acute.

Parents were supported to assert their lifestyle identity and independence during the child protection conference by a voluntary body, acting in an official capacity. Professional concerns and assessment of risk were robustly and heatedly challenged within the conference process, which in itself was alleged to be discriminatory to the mother's right to choose an alternative lifestyle.

Some professionals were targeted and challenged about their information sharing role in the interval between the professionals meeting and conference.

The child protection conference decision to register the children, including the unborn child, under the category of neglect was not unanimous.

The subsequently allocated social worker (SW) did not attend the conference and not ever having visited the site, managed the case through other involved professionals, not all of whom were invited or attended the two child protection core group meetings that were subsequently held.

The pregnancy progressed with maternal engagement and compliance with drug services, allowing Child 1 born three weeks before due date, to have recovered sufficiently to be discharged home on day eight. Maternal co-operation and targeted midwifery and drug services support are acknowledged and are commended.

Similarly housing services are to be commended for sustained and continuous efforts to effect change for the children by exploring all avenues and eventually expressing health and safety concerns to director level.

No child protection plan, however, had been prepared at either of the core groups in the eight weeks following conference. No plan was therefore revisited and revised to accommodate the possible needs of a vulnerable baby discharged to a home environment not considered ideal for older children.

Meanwhile professionals' focus continued to be on parental hopes and aspirations for the acquisition of suitable accommodation that reflected their lifestyle choices. This was seen as the one solution to all problems. However, the focus on this meant that the children's immediate needs were not prioritised and an assessment of the totality of the children's living experiences in an unsafe environment was not done.

The full report of the serious case review was completed and a series of recommendations made in respect of the serious case review and work commenced to implement lessons learned within respective agencies.

### **Ofsted Judgement and Subsequent Review**

On January 30<sup>th</sup> 2009 the Isle of Wight Safeguarding Children Board (LSCB) was notified by Ofsted that the serious case review (SCR) undertaken as above was judged as being inadequate overall.

In the main this related to process issues, concerned with the independence of the overview report author and the quality of a small number of the IMR's judged as inadequate. Other IMRs were judged as outstanding, good and adequate overall. The overview report was considered to require a strengthening of rigour and analysis, and as having failed to capitalise upon the quality of some of the evaluative work of the IMR's.

Following notification of the Ofsted judgement, the IOW LSCB commissioned the services of an independent overview author and of an independent chair 'of sufficient authority and experience and independent of all reporting agencies' in accordance with DCSF guidance. A SCR panel was re-convened, revised terms of reference were drawn and the relevant actions undertaken accordingly.

It was established that whilst the family had declined to take any part in the original review they did want to share their views with the new independent chair and independent author who subsequently met with the family.

The parents spoke of some professionals being supportive and balanced in their approach, while others they felt were dismissive of the positive elements of their family circumstances. They identified a lack of continuity in the professionals supporting them, with a succession of different social workers. The parents felt their voices, and that of their children were not heard or considered and they felt that the focus was not on the needs of the children, but on the issue of the family's chosen lifestyle.

The panel has undertaken a thorough and systematic review of all aspects of the serious case review, including the extent to which process issues may have contributed to the Ofsted judgement.

Identified issues have been translated into more robust judgements and specific outcome focused recommendations as appropriate. In some cases this has entailed sharpening the focus of original recommendations through rewording, in others new recommendations have been made. This is particularly relevant in respect of LSCB serious case review processes. Overall the panel did have confidence in the integrity of the conclusions of the original SCR and did not consider there to be a need to revisit the SCR in its entirety.

## **RECOMMENDATIONS**

These include recommendations which featured in the original serious case review, some of which may have been reworded to sharpen or strengthen their focus, and new additional recommendations.

## **Children's Services (Social Care)**

The IMR author made the following recommendations for children's services, (social care):

1. Children's social care services, when coordinating the work of other professionals, should ensure that there is a common understanding of what constitutes risk to children, and that, before cases are closed, proper assessments are undertaken and, if necessary, action taken to safeguard children.
2. The chair of a child protection conference should ascertain the responsibilities and accountabilities of each professional for the case at the start of the conference and ensure that responsibility is appropriately transferred pre and post conference.
3. Senior managers should review the current decision making process at case conferences to a consideration of one vote per agency.
4. The chair of a child protection conference must ensure that outline child protection plans are developed within the conference which are comprehensive, detailed and specific about time scales and areas of responsibility.
5. The conference chair should monitor and audit core group plans with regard to content and time scales.
6. Team managers must take ownership for auditing the content of the child protection plans, ensuring that all professionals have a copy of the child protection plans within 5 working days of core group meeting.
7. The chair of a child protection conference should ensure that all unborn children subject to child protection plans have a plan forwarded to maternity services within 10 working days of conference and the plan is revisited and revised as appropriate before the child is discharged from maternity unit.
8. To ensure a seamless transfer of a case, the social worker completing the section 47 assessment for an ICPC should always attend the initial core group meeting.

### **Further recommendations**

9. The Director of Children's Services should establish a list of core competencies essential for any person chairing child protection conferences. These should require the chair to be of sufficient seniority, expertise, experience and authority to ensure that conferences are conducted in a professional way leading to the production of high quality outline child protection plans.

## **Children's Services (Education):**

The IMR author made the following recommendations:

10. The Education Management Systems (EMS) should be updated to enable an audit trail and retrieval of all EWO records within an acceptable timeframe.
11. To develop a protocol that when new children or young people are identified as having moved to the IOW universal services and health and social care are informed as a matter of course, with an audit trail to confirm the same.

### **Further recommendations**

12. The Local Education Authority should satisfy themselves that, where there are children in need /at risk with additional concerns who want to be educated other than at school, a full assessment (e.g., CAF) is undertaken, which would assess the appropriateness of the learning environment and the possible risk factors that can impede a child's ability to thrive and learn.

### **Health Visiting**

The IMR author made the following recommendations for the health visiting service:

13. Health visitors should ensure that information on how to prevent SIDS is given and clearly documented in records, and that sleeping arrangements are recorded and reviewed at each visit.

### **General Practice**

The IMR author made no recommendation. The independent chair and author made the following recommendation.

14. GPs should be proactive when they are aware of a child being subject to a CP plan, particularly around home visiting, attendance at / information provided to conference.

### **Midwifery**

The IMR author made the following recommendations:

15. There should be a documentation review for the midwifery service with regard to completion of all paperwork prior to discharge from the unit and community. Documented evidence must reflect all advice given.
16. The midwifery service must ensure the process of discharge within the Unit involves one professional to complete comprehensively. If this process is affected by shift change or transfer of staff to another area the professional taking over the care, prior to discharge, must repeat the process so that all documentation is complete.
17. The relevant midwife should ensure that all unborn babies subject to CPP have a birth plan in the maternity notes within 10 working days of the conference and that the CPP is revisited and revised as appropriate before the child is discharged from the unit, and audit the same.

18. The relevant midwife should ensure that registration on the CPP with the category is communicated to the GP in the infant's discharge summary.

### **All health agencies:**

The independent chair and author made the following recommendations, for all health agencies, severally and together:

19. Discharge policies should be reviewed and take account of agency and parental views, ensuring effective plans for post discharge and future support. This should be audited regularly and reported to the LSCB.
20. Health agencies should develop a collective policy on SIDS and ensure that appropriate training and knowledge is disseminated.

### **Police**

The author of the IMR made the following recommendations:

21. Officers should be offered training in the identification of children at risk who would benefit from interagency receipt of CYP and CA/2S (children at risk forms).
22. Officers should be required to complete detailed working sheets on the Records Management System (RMS) when attending occurrences that may relate to child neglect.
23. Officers should receive and understand the protocol for dealing with the resuscitation of a child in infancy and the need for consideration of all sudden infant deaths to be escorted to A&E rather than the mortuary.

### **Island Drug and Alcohol Service**

The author of the IMR made the following recommendation:

24. A safeguarding log should be developed for each client that clearly identifies safeguarding concerns, perceived risks and action taken pertaining to each individual child within the family concerned.
25. Triage assessment should capture information regarding children, which clearly shows the name, date of birth of each child and whether or not they are known to Social Services. This information must also be logged on the Database and updated to reflect any changes in circumstances i.e. CP Registration.

### **Ambulance service**

The IMR author made the following recommendation:

26. The ambulance service should work with medical colleagues from the emergency department and paediatrics to ensure ambulance protocol for dealing with the resuscitation of a child including sudden unexpected death in infancy is in line with current guidance. This needs to be followed up by making

sure all staff have received and understood the above information, and have in place a robust system to ensure this and record it.

**Further recommendation:**

27. The ambulance service should ensure ambulance crews have independent means of communication with the control centre in all circumstances.

**People Off the Streets (POTS)**

The IMR author made the following recommendations:

28. Supporting People should give consideration as to how SP providers can develop improved means of distinguishing and separating personal support to and empathy with clients from the delivery of professional services as an SP provider.

**Further recommendation:**

29. As with all agencies supplying front line services or support to children and families, the managers of POTS should be required to attend CP training and review supervision standards in line with LSCB criteria.

**All agencies**

It is recommended that all agencies ensure that:

30. Any child found to be suffering from an infectious condition has access to, and receives medical care within appropriate time scales, whether from a GP or emergency services.
31. Failure or inability to complete assigned tasks which form part of a child protection plan is communicated effectively to inter-agency colleagues with an assessment of risks in a timely manner.
32. Current recording policies are reviewed and all contacts and communications are clearly recorded on relevant case files.
33. All agencies, heads of service and line managers participate in regular agency and inter-agency audits of professional record keeping with particular reference to auditing when children were seen/heard/assessed.
34. There is a review of current supervision processes, ensuring effective documentation of discussion about the safeguarding of children. Supervision notes should record concerns, actions, outcomes or the absence of concerns.
35. All relevant agencies who have contracts with external providers which involve working with children and families have sound safeguarding policies and procedures in line with current statutory guidance, including child protection training, supervision and clear lines of management.
36. They appoint lead officers in diversity and ethnicity to provide expertise, advice and support to staff.

## **Agencies working with families – Social Care, Education, Health, IDAS, Police**

It is recommended that the above agencies ensure that:

37. All cases where children are perceived as at risk of neglect are discussed in supervision. Appropriate assessments should be made which clearly identify risks which might impede a child's development. Progress towards change should be monitored on a regular basis.
38. All professionals, including line managers, have access to training in recognising chronic neglect, with particular reference to Reder and Duncan: disguised compliance, control conflict, assessment paralysis.
39. Relevant agencies develop protocols to manage cases where sensitive information is not shared and where the decision of a CP conference could be compromised by the lack of relevant information.

## **Isle of Wight Safeguarding Children Board**

It is recommended that the LSCB:

Improve working together:

40. Work with agencies to develop shared and consistent
  - definitions of neglect
  - thresholds for intervention and action
  - mutual respect in an inter-agency context
  - understanding of each other's roles
  - understanding of research and statutory issues
  - training programmes relating to neglect.
41. Require agencies to clarify their powers and responsibilities in relation to children who may be living in unhealthy, unsanitary or unsafe environments. This guidance should be available to staff and appropriately disseminated with policies and guidance in relation to neglect.
42. Develop a policy on dispute resolution, to be reviewed annually.

Review and monitor the quality and effectiveness of safeguarding and child protection on the Isle of Wight:

43. Undertake a multi-agency file audit of children subject to child protection planning, to monitor
  - Recording
  - Protection plans, both from the conference and core group
  - Timescales
  - Role of lead professional
  - Case transfer
  - Quality and frequency of supervision

44. Establish and monitor standards for child protection conferences:
  - Chairing
  - Core representation
  - Minuting
45. Develop and issue guidance on recording the involvement of children and a focus on their well-being, and require agencies to review their recording policies.
46. Review the policy, status and purpose of professionals' meetings. The principle that any professional may call a meeting when concerned about a child is sound: such meetings should have a clear purpose, a core agency membership and produce clear plans.
47. Review current child protection training for practitioners and managers in all agencies.
48. Review the role of family group conferences in the Isle of Wight to ensure that opportunities are maximised to work in partnership with families and the wider community to safeguard children.

### **Serious Case Reviews**

49. Review LSCB business processes to ensure the identification and notification of cases which may require a serious case review and ensure that appropriate processes are in place in all agencies.
50. Commission the Serious Cases Working Group to develop expertise in undertaking IMRs in individual agencies through a training programme, and quality assurance systems.
51. Appoint an independent person to monitor the outcomes of the action plan resulting from these recommendations within 12 months of this report being accepted by the LSCB.