Executive Summary of
SERIOUS CASE REVIEW
Concerning 'A' d.o.b 22.3.96 - d.o.d 18.4.06

Report commissioned by
BRISTOL SAFEGUARDING CHILDREN BOARD

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1. Introduction

1.1 The Chair of the Bristol Safeguarding Children Board received two requests, one from the South and West Primary Care Trust and one from Avon and Somerset Constabulary, to instigate a Serious Case Review, following the death on 18th April 2006 of child A, aged 10 years. A had died from coronary arrest when she had fallen into a bath of scalding hot water at her home, and it was felt that generalised and chronic neglect, including non-attendance at medical appointments may have contributed to her death.

1.2 The BSCB Executive agreed to undertake a Serious Case Review on 19th July 2006.

2. Terms of Reference

- Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

- Identify clearly what these lessons are, how they will be acted upon, and what is expected as a result.

- To improve inter-agency working, better safeguarding and promoting the welfare of children.

- Identify if there was a failure to provide adequate supervision and ensure access to appropriate medical care or treatment.

3. Contributions to the Review

Individual Health Management Reviews undertaken by:

Jacalyn Mathers	-	Designated Nurse for Child Protection (CP), Bristol and West Primary Care Trust (BSWPCT)
Jo Walsh	-	Named General Practitioner, Child Protection BPCT
Carol Sawkins	-	Named nurse for CP, United Bristol Healthcare Trust (UBHT)

4. Confidential overview report and chronology compiled by:

Juliet Norman	-	Child Protection Advisor, Bristol North PCT
Lucy Young	-	Planning and Development Manager (Safeguarding) C & Y P Services

Chris Stevens	-	Principal Education Psychologist/CP Lead (Schools)
DCI David McCallum	-	Head of Bristol Public Protection Unit, Avon and Somerset Constabulary

5. Family Involvement

A's mother has been visited by a representative of Children and Young People's Services to explain the serious case review process, and she was invited to contact the Chair of the Overview Panel direct if she had anything she wanted to contribute to the Review. A's father has not been contacted as he has left Bristol and his contact details are not known.

6. Family Characteristics

A was the fourth child in a family of eight children. Three children (A's elder siblings) are mixed origin. The remaining five children are White UK and there are three different fathers. A's parents are White UK. The extended family consists of A's maternal grandmother who is separated from A's maternal grandfather and the paternal grandmother of one of A's older siblings.

7. Overview of Relevant Information

The combined family history contained within agencies' records going back over 14 years was reviewed by the Case Review Panel, and several features appeared as significant. These were that:

- the family had several changes of address
- there were several anonymous referrals to Social Services expressing concerns about the care of the children
- the children suffered numerous accidental injuries and access to health care was usually out of hours GP services and at A & E Depts
- suspected drug misuse and alcohol abuse by adults in the household
- incidents of domestic violence
- racism/racial abuse
- behaviour problems with the children
- one child became a Looked After Child
- mental health issues were identified in the parents
- physical conditions in the home were of concern

8. Child Protection Registration

All of the children's names were placed upon the Child Protection Register from May 2003 – January 2004 under the primary category Emotional Harm, with the secondary category Physical Abuse.

9. Conclusions

9.1 There were missed opportunities for professionals to intervene in the early years, which could have focused upon parenting support. There was a lack of critical analysis of known information with incidents being treated discretely in isolation from each other, which contributed to an underestimate of the amount of neglect that the children in the family were experiencing.

9.2 Social services had intermittent involvement from 1993 – 2000, with assessments made that the referrals received did not reach the thresholds for social work intervention. Concerns escalated from 2001 with a number of domestic abuse referrals and allegations of physical abuse by the father/step father. The children were briefly placed on the Child Protection Register.

9.3 There were few occasions when the childrens' views were sought. The parents were hostile to social workers, and this could have impacted upon professionals' ability to speak with the children. **Recommendations 10.1.12, 10.2.1, 10.2.2.**

9.4 When the agencies chronologies were combined, there was documented evidence of chronic neglect of all of the children over a number of years. Large, mobile, neglectful families present a significant challenge to professional agencies to intervene effectively, and information was not always shared amongst professionals, and at times, there was disagreement amongst professionals about the thresholds for intervention. **Recommendations 10.1.6, 10.1.7, 10.1.8, 10.1.9, 10.1.10, 10.2.3.**

9.5 Apart from the brief period of child protection registration, there was no systematic assessment and this contributed to the professionals' failure to grasp the seriousness of the situation for the children in the family. **Recommendation 10.2.4.**

9.6 Although there was evidence of good professional practice, this was not co-ordinated by multi-agency planning which focused upon outcomes for the children and therefore it brought little change to the overall situation.

9.7 Several factors contributed to the lack of recognition of the level of neglect:

- The variable quality of health service record-keeping.
- Lack of systematic follow up to missed appointments across diverse health professionals. **Recommendations 10.1.3, 10.1.4**
- The number of changes of address and the resulting need to transfer information.

- Numbers of professionals involved over the years and across agencies/ organisations.
- Significant information was not always shared successfully between agencies..
- Assessments made by other agencies (e.g. Child and Adolescent Mental Health Service) were not used to inform social care planning, so information gained via one process (e.g. Looked After System) was not used to inform social care planning for the wider family.
- School records were not kept together i.e. confidential information, which may contain child protection information records were not kept with academic records. This contributed to the partial transfer of information when children changed school. This practice has serious implications for the ability of educational professionals to be able to respond appropriately in risk situations and to be able to contribute in an effective and informed way in assessment processes. **Recommendation 10.4.1**
- Significant indicators of risk were viewed in isolation e.g. numerous descriptions of 'accidental' injuries to the children, the number of anonymous referrals expressing concern and the number of domestic violence incidents. When put together, these paint a more worrying picture than when viewed in isolation.

9.8 Professionals failed to gauge the level of actual neglect being experienced by the children and consequently the view held by professionals was that the threshold for child protection intervention was not met.

9.9 At various times there was a failure to provide adequate supervision for all of the children, as well as a failure to ensure access to appropriate, timely medical care. **Recommendations 10.1.3, 10.1.5, 10.2.3.**

9.10 In the imminent lead up to her death, it was known amongst professionals that A was not taking her medication for epilepsy because the bottle had been broken, but her mother was aware of this and she had said that she was going to get some more from the GP. There was a lack of clarity about the degree of risk that the family's non-compliance with health appointments and medication presented. If professional activity had been more co-ordinated, then it could have more effectively ensured that A had access to a supply of medication. **Recommendations 10.1.1, 10.1.2, 10.2.3.**

9.11 There is no way of knowing whether the fact that A was not taking her prescribed medication contributed to her death. It may not have been unusual for the 10 year old, who was possibly suffering black outs, to be running a bath unsupervised, and her parents were probably unaware of the risk that this posed. The thermostat on the boiler was faulty, and this had not been reported to the housing department. These risk factors combined, and resulted in the tragic accident in which A died.

9.12 This review has identified recurrent themes found in previous reviews:

- inadequacies of assessment
- agencies' inability to communicate with each other effectively
- the lace of attention to the 'voice of the child'

9.13 In looking back over 14 years of professional involvement, the review panel has been cautious about making recommendations which will be no longer relevant for current practice. The recommendations, therefore, focus upon specific procedural or service deficits which the review highlighted.

10. Recommendations

10.1 Health

10.1.1 Hospital Trusts in Bristol ensure that the support of an Epilepsy Nurse is available to all paediatricians managing children with epilepsy, to emphasise safety precautions and provide further information about epilepsy and its treatment.

10.1.2 Hospital Trusts in Bristol ensure that children with epilepsy and their parents/carers are provided with information about safety precautions, and management of the child's epilepsy, and that this is documented.

10.1.3 Hospital Trusts in Bristol develop a policy on 'did not attend'. This needs to include consideration of whether there are child protection issues and if so a letter to all concerned informing that the child did not attend, whether the appointment is being re-booked, and how to go about seeking a further appointment if required. This needs to take into consideration the recommendations of the National Service Framework for children, young people and maternity services (DH 2004) to fully assess/ address the potential child protection implications for each child.

10.1.4 The named GP ensures that there is a GP policy on did not attend if this is not already in place.

10.1.5 Community paediatricians should offer local clinics which are appropriately staffed and supported.

10.1.6 A brief, accessible summary/chronology to be kept in an identified set of health care notes on the whole family which identifies significant events and issues of concern.

10.1.7 A sheet should be included in the front of all health visitor records which should be signed when an entry is made. This would allow staff to identify how many people have been involved with the family and the level of responsibility. This would adhere to the Nursing and Midwifery Council Guidelines

for Records and Record Keeping (2005), which states 'the entry should be signed … with the signature printed …' .

10.1.8 A separate sheet should be included for address changes to provide a clear chronology of house moves.

10.1.9 That there is a formal review of health visitor records and guidance is given to the filing of notes in records to ensure a consistent approach across the Primary Care Trust.

10.1.10 When health visitor records transfer to another clinic, a clear note is made on the record of when they are sent and received.

10.1.11 The recommendations are shared and adopted across hospital trusts so that all children using the services of the United Bristol Healthcare Trust or North Bristol Trust will receive the same standard of care.

10.1.12 All health professionals need to record the child's expression of wishes and feelings where these can be identified.

10.2 **Children and Young People's Services - Social Care**

10.2.1 Managers should ensure that children are interviewed in the course of assessment and assist social workers to develop strategies to ensure this happens. Children and Young People's Services staff should be clear with parents that this is a requirement for assessment.

10.2.2 Managers should ensure that procedures are followed to ascertain the child's view prior to closure.

10.2.3 Children and Young People's Services should formally inform child health when a case is closed so that when health professionals have a concern they know whether or not there is current social work involvement.

10.2.4 Children and Young Peoples Services social care managers should ensure that regular multi-agency children in need reviews are held in accordance with procedural guidelines and that all relevant agencies are involved. At each child in need review, consideration should be given as to whether or not a new core assessment should be undertaken.

10.3 **Police**

10.3.1 This case has highlighted no police specific issues or recommendations.

10.4 **Children and Young People's Services - Education**

10.4.1 The Lead for Child Protection (Schools) to issue guidelines to Headteachers about storing confidential information and forwarding this information when a pupil leaves their school.

10.4.2 The Programme Director (Partnerships and Localities) ensures that all home educated pupils receive regular monitoring visits as per DFES (Department for Education and Skills) guidelines.

10.4.3 All teachers whose responsibility it is to make home visits are trained in child protection.

10.5 **Overview recommendations – Chair**

10.5.1 The Bristol Safeguarding Children Board consider a format for training/preparing Reviewing Managers involved in Serious Case Reviews about their role and responsibilities.