Leicester Safeguarding Children Board

Serious Case Review – Child A1 Review Briefing

Introduction

This summary/briefing is aimed at managers and practitioners working with children and families in Leicester. The key learning emerging from the Child A1 review and recommendations are presented.

The Child A1 Serious Case Review (SCR) is a review of the life of a nine week old baby, who died of an underlying natural cause. The child may have been likely to die of this cause, regardless of any care that they received during their tragically short life, during which the child was either in foster care or in hospital. However, after death, Child A1 was found to have a number of non-accidental rib fractures. A criminal investigation was inconclusive and no charges were brought in respect of those injuries.

There were no singular failings that led to the child's death. There was however, a lack of continuity, joined up activity, and record keeping. There was also a lack of impetus and attention to detail within Children Social Care which included a lack of management oversight. CHILD A1 was not always considered as an individual. CHILD A1 was looked at as part of a wider picture becoming part of the process as opposed to being seen as a person in their own right.

Working Together to Safeguard Children (2015)

Working Together states that where abuse or neglect of a child is known or suspected and the child has died, then the Local Safeguarding Board (LSCB) must initiate an SCR. The purpose is to enable the professionals and organisations involved with the child and their family to reflect on both their practice and that of others, to identify improvements that are need to consolidate good practice.

The LSCB SCR sub-group following extensive investigations into the death of Child A1 recommended to the LSCB Independent Chair that a SCR should be conducted, which was agreed by the Chair.

Good Practice

Strong practice by individuals and agencies was identified in the review.

The health visitor met with the birth mother, foster carer and child while Child A1 was still in hospital and had a clear picture of the family dynamics. The health visitor kept exceptionally good records of contact.

Three fostering supervision visits were made to the foster carer during the period between Child A1's initial discharge from hospital and death. This identifies a good level of supervision and support to the foster carer.

What Happened?

- Child A1 was born prematurely, at approximately 32 weeks gestation. Child A1 was a concealed pregnancy; consequently the mother had received no ante-natal care. This was the mother's second concealed pregnancy. The other siblings of Child A1 were not in their parents' care at the time of the birth. One of the siblings was in the care of a foster carer and subject to care proceedings with adoption being the proposed care plan.

- Child A1's needs were identified by the hospital, midwifery and health visiting service. However, this pregnancy was concealed, therefore professionals were on the 'back foot' and lacking in any multi-agency pre-birth assessment which had wide ranging implications on the agencies.

- Procedures for a new case (or birth of sibling known to Children Social Care) were not followed. The Independent Reviewing Officer (IRO) who had been informed by Duty & Advice Service (DAS) had notified the siblings social worker who was allocated the case – passing the 'front door' process resulted in some safeguarding actions being missed such as strategy meeting.

- The sibling was subject to care proceedings and the IRO agreed with the social worker that an Initial Child Protection Conference (ICPC) along with a Looked After Child (LAC) review was required; no other agencies were notified by any formal or information referral for discussion.

- The ICPC did not take place and there were no recording of the communication between the IRO and social worker, therefore tracking of key decision making was not possible.

- Child A1 was placed with the sibling's foster carer (who was an experienced foster carer, and considered to be suitable to deal with Child A1's needs). However, Child A1's needs should have been considered in child's own right and be placed with a foster carer who was able to meet Child A1's actual and anticipated health needs. A placement with the sibling meant that Child A1 was becoming 'lost' into on-going matters and placed into existing arrangements.

- Records relating to the foster carer were not comprehensive.

What Happened? (cont'd)

- Child A1 was discharged in the care of the foster carer following the granting of an Interim Care Order. Following discharge Child A1 was a Looked After Child (LAC). Due to annual leave and sickness of the social worker and IRO, there was no 72 hours meeting, as required by local procedures, with the first meeting being the statutory 28 day review. This meeting took place five weeks after Child A1's birth. There should also have been an initial LAC medical (a statutory requirement) but the relevant health professionals and the designated LAC nurse was not advised of Child A1 going into foster care.
- Two weeks later the foster carer raised concerns regarding Child A1's poor circulation and presenting as cold, and took Child A1 to the GP who immediately referred the child to hospital. Child A1 was discharged from hospital after 5 days.
- It is noted that the foster carer informed the social worker of Child A1's hospital admission by e-mail (the supervising social worker was not informed). The review author questioned this method of communication as more direct forms of communication (e.g. texting) may provide more direct, timely and effective dialogue.
- The first statutory review meeting that took place in the hospital was attended by (just) the social worker, health visitor and IRO – it was poorly attended. The foster carer or supervising social worker were not present. An adoption plan was agreed.
- Child A1 was discharged from hospital, then on a further two occasions the foster carer took the child to the GP. The child was also admitted to hospital and discharged to the care of the foster carer.
- Less than two weeks after this the foster carer took the sibling to pre-school and was continuing to an appointment for Child A1, when she noticed that Child A1 (who was secured in a car safety seat) appeared to have stopped breathing. She called for assistance and a passer-by to help with resuscitation, and the paramedics took over when they attended. Despite their best attempts Child A1 was declared deceased on arrival to the hospital emergency department. The death was reported to the Police as a sudden and unexpected death of a child.
- Sudden child death protocols were initiated and the initial post mortem authorised by the HM Coroner discovered what appeared to be non-accidental injury (NAI). This involved rib fractures. Paediatric pathology was immediately stopped for police led investigations. A criminal investigation into the cause of the injuries was inconclusive and no charges brought.
- A coroner's inquest found that no cause of death could be identified and that fractured ribs was not the cause of death or a contributory factor – an open verdict was recorded.

Why this happened?

- The review author found the LLR LSCB concealment of pregnancy procedures to be comprehensive. Although Child A1 was born just prior to being admitted to hospital, these procedures should have been implemented as Child A1 was a concealed birth and no-one knew or had been able to carry out pre-birth assessments. Consequently Child A1 became part of an on-going process regarding the sibling as opposed to a child in need of protection in their own right.
- The IRO correctly identified the requirement for an ICPC and agreed by the social worker, but this did not happen. At the time there was no process or system in place within the Safeguarding Unit to ensure that required ICPCs took place. However current monitoring processes within the Safeguarding Unit would pick this up now.
- Proceedings were appropriately identified and acknowledged; however, no other agencies (e.g. Police) were notified by any sort of referral, which should have occurred.
- A number themes developed during the review process:
    - A lack of an assessment (recorded) of Child A1's placement needs
    - The lack of an understanding of the pre-existing concerns regarding the foster carer
    - A lack of meetings e.g. S47, strategy meeting, ICPC, 72 hour post placement meeting, an initial LAC health Assessment – all of these impacted on safeguarding and planning
    - Inadequate case recording with CSC
    - Lack of supervision and management oversight. Child A1 was allocated to an experienced social worker who had an acceptable and manageable case load.
- Child A1's overall safeguarding was not properly considered in a joined-up approach from birth and procedures not followed. The 1st social work visit did not take place until a few days before the child's death. Consequently there was no coherent multi-agency safeguarding plan during Child A1's short life. Some missed opportunities were identified.
- Child A1's placement with the foster carer should been considered more carefully in light of the child's assessed needs as an individual and pre-existing concerns.
- There was no initial LAC health assessment because the 'designated looked after children nurse' was not informed of Child A1's birth. This is statutory requirement, in the review's view is that any such initial assessment for under 5's should be made by a paediatrician.
- The management of these areas was lacking which stems from the failure at the initial decision making stage and thereafter not following the practice and procedures in place – they just did not give this case a high enough priority.

What needs to be done now to prevent similar incidents?

Improvement work has already taken place within the partnership during the period since the death of CHILD A1. The following recommendations were made, which will continue to improve practice within Leicester City.

1. The LSCB should seek assurance from CSC that all children that become looked after have an assessment of their needs within 72hrs and their initial health assessments are completed within the statutory 28 days.
2. The LSCB should seek assurance that the work currently on-going within the partnership to improve section 47 strategy meetings and discussions is making the necessary improvements.
3. The LSCB should seek assurance that: i) in 'Concealed Pregnancy ' cases an ICPC takes place that ensures focus is then made on that individual child, ii) in cases where children are removed at birth (where no pre-birth assessment had taken place) the appropriate child protection procedures are followed and iii) that assessments still take place even where there are already siblings' subject of safeguarding processes.
4. The LSCB should seek assurance from CSC that their current improvement plan includes case recording and adequate demonstration of consistent supervision and management oversight on cases. This needs to ensure that the improvement plan makes the necessary improvements required to prevent the issues identified in this case.
5. The LSCB should seek assurance that the Fostering placement and support service are i) linking in with the LADO when complaints are made about foster carers, and ensure that the chronologies in relation to the foster carers are kept up to date. ii) They should ensure that the Fostering placement and support service is adhering to 'Notifiable Incidents under schedule 7 of the Fostering Services (England) Regulations 2011.' In addition to this foster carers and supervising social workers should be re-issued with guidance on methods of communication with each other and what instances should be referred. iii) They should consider whether Foster carer reviews should be carried out by an Independent person.
6. The LSCB should seek assurance that where indicated the multi-agency child death procedures for unexpected child deaths of children under 2 years, ensure that a skeletal survey takes place at the earliest opportunity possible so the results are available to inform the post mortem.
7. The LSCB should ensure that there is a clear procedure with regard to the relationship between serious incident investigations, serious case reviews and LADO investigations.

Further Information

- The SCR overview report on the Child A1 review and this briefing is available at: http://www.lcitylscb.org/safeguarding-learning-development-training/learning-from-serious-case-reviews/

- Learning in relation to Fostering (Warwickshire LSCB SCR) and Special Guardianship Order (Birmingham LSCB SCR) from published SCRs is available at:

  https://apps.warwickshire.gov.uk/api/documents/WCCC-850-618

  http://www.lscbbirmingham.org.uk/images/Feb17_Briefing_Note_-_BSCB_2015-16-02.pdf

- Published SCRs are available from the NSPCC SCR repository at: https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository/

- LLR LSCB multi-agency safeguarding procedures are available at: http://llrscb.proceduresonline.com/chapters/contents.html

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