Serious Case Review

Overview Report
Executive Summary

in respect of

Baby A

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EXECUTIVE SUMMARY

Introduction

1.1 This review was requested because the previous serious case review into Baby A was graded as 'inadequate' by Ofsted. Reasons for this included:

- A lack of independence in the previous serious case review process which led to some compromised individual managements reviews and compromised membership of the original serious case review panel;
- The terms of reference were too narrow;
- The overview report was felt to be too focused on the mother's possible mental health problems rather than on the needs of the child and lacked depth from reference to research or other serious case reviews. It was also felt to lack sufficient analyses of family background or extant family relationships and the family's diversity needs.

1.2 This review attempts to address the criticisms made by Ofsted.

Background

2.1 Baby A suffered extensive and permanent brain damage at seven days, as a result of dehydration due to neglect possibly compounded by Vitamin K deficiency.

2.2 His mother had made allegations of domestic violence when she was 37 weeks pregnant. The allegations coincided with a sudden and dramatic change in her behaviour and attitudes towards all those professionals trying to work with her. From being described as merely and understandably 'anxious' (Baby A was a first child) she became very uncooperative and hostile, refusing all medical and other interventions designed to help both her and her baby. For example, Baby A's mother suffered from symptomatic pre-eclampsia which posed serious dangers to her own health as well as that of Baby A. The allegations of domestic violence were also withdrawn (prior to Baby A's birth), and intervention then focused on her obstructive behaviours and whether she was suffering from mental ill health.

The serious case review raised a number of issues:

The conflict of interests between the welfare and longer term health needs of Baby A and the wishes, and feelings of his parents and especially his mother, and how professionals might best intervene in such situations.

2.3 Baby A was denied Vitamin K by his mother as a prophylactic at birth and then again at days 5 and 6 as a treatment, when he had been readmitted to hospital suffering from dehydration. Vitamin K deficiency is associated with Haemorrhagic Disease of the Newborn (HDN) (8.6 per 100,000 neo-nates) and Baby A appeared to suffer from classic

HDN. He had a ‘general seizure’ at 6 days, and was found to have extensive intracranial bleeding (bleeding to the brain) which is also indicative of non-accidental injury (NAI).

The importance and role of Emergency Duty Teams (EDTs)

2.4 Several ‘key’ events took place at weekends, in the middle of the night and over bank holidays. The knowledge held by the Emergency Duty Team about Baby A’s possible needs, and the ways they should be responded to, and the advice given to midwifery and obstetric staff, raised important points for the relationship between the Day Team and the Emergency Duty Team.

The centrality of inter-agency meetings and the importance of strategy and planning.

2.5 There was a significant delay in convening a strategy (or any other inter-agency) meeting. Hence the various strands of Baby A’s plight were not brought together quickly enough (pre-birth).

2.6 The delay allowed the allegations of domestic violence (although withdrawn) to remain entirely unexplored.

2.7 Whilst individual to individual communication was good and prompt, the delay in meeting together hampered the development of any collective understanding of Baby A’s situation and hence no thresholds for statutory or other interventions were agreed.

2.8 Additionally, the absence of inter-agency planning meant that there was no co-ordinated plan to manage the occasionally bizarre and often obstructive behaviour exhibited by baby’s A’s mother, particularly towards midwifery and other medical staff. This inevitably sucked medical *and* other energy away from a clear focus on *Baby A’s* needs.

2.9 Similarly, the few available opportunities to engage in joint multi-agency work (such as assessment – see below) were missed.

The importance of assessment.

2.10 Baby A’s mother refused contact with and/or was obstructive and uncooperative towards most professionals including social workers. Prior to birth, professionals were of necessity limited in the action they could take. The difficulties of pursuing an assessment in these circumstances should not be underestimated. Nevertheless, such difficulties were a significant indicator of the need to use all available opportunities to collate information, seek specialist advice and progress an assessment (see above). Further they should have prompted an early planning meeting.

2.11 Post-natal, the difficulties of constructively engaging Baby A’s parents in an assessment continued along with his mother’s problematic behaviour. Events moved very quickly (he suffered serious head injuries due to neglect, probably compounded by Vitamin K deficiency) at 6 days. This should remind all parents and professionals alike, that infants are particularly vulnerable to persistently non-compliant, and non-cooperative parental behaviours. It underlines the importance of assessment and indicates the need to ‘escalate’ concerns quickly.

The Importance of Constructive Multi-Agency Working

2.12 Baby A’s situation was complex, involving allegations of domestic violence by Baby A’s father and retaliation by his mother; medical problems – pre-eclampsia; possible mental health problems; obstructive and hostile behaviour and non-compliance with medical and

other advice. Apart from reinforcing the necessity of meeting together and planning a strategy and assessment, such complexity inevitably involves the need to be clear about the roles, responsibilities and boundaries of ‘other’ agencies and disciplines, as well as acknowledging that perceived need may not neatly fit in with the boundaries of any agency. Hence, the need to work closely with partner agencies to support, advise and agree a plan of action in cases that do not clearly fall within the remit of any one service underpins all the recommendations.

Recommendations

National / Regional

3.1 The London Safeguarding Children Board should develop guidance which helps medical and other professionals *speedily* resolve conflicts of interest between the welfare (including longer term health needs) of unborn and neo-natal babies and their parents’ wishes and feelings.

The guidance should reinforce the value of prophylactic care at birth, the law as it relates to children’s ‘rights’ for preventative treatment (where they are not Gillick or Fraser Competent) and be sensitive to the needs of a diverse population.

3.2 The London Safeguarding Children Board should ask that the rules and best practice regarding the anonymisation of Individual management reviews and serious case reviews to be urgently clarified by Ofsted and appropriate guidelines developed. Additionally, guidance should be produced to clarify the need for independence in serious case reviews between for example the roles of chair of panel and overview author. (by end of December ’09)

Royal Borough of Kingston LSCB

3.3 The LSCB should commission an analysis of the need for a Hospital Children’s Social Work service which might provide a direct link to the Children’s Social Services department. The analysis should investigate the numbers and types of referrals to Children’s Social Services from hospital sources, their progress or otherwise, and whether such a service would add significant local benefit. (by end of September ’09)

3.4 All agencies should attend LSCB inter-agency training re: working with uncooperative families. The programme commences in 2009-2010. The LSCB Training Sub-Group should monitor and report on the attendance of staff by agency. (Actioned)

3.5 The LSCB inter-agency training programme should include modules concerned with:

a. Raising awareness of and developing best practice in assessment of cultural, racial and religious aspects of immediate ante and post partum child care and;
b. ‘Pre-birth concerns’; concentrating on the necessity of early referral and assessment, the significance/meaning of medical terminology, and the importance of engaging expectant fathers in the assessment process.

(by end of December ’09)

3.6 LSCB should review the existing Children’s Social Services /Community Care Services protocol on joint work with parent/carers with mental health difficulties; particularly focusing on the roles and responsibilities of staff in the acute hospital setting and their link to the community teams. (Achieved)

3.7 LSCB should sponsor joint training of Children's Social Services Safeguarding workers and Community Care Services CMHT workers to improve reciprocal understanding of roles and responsibilities with a focus on the scope of assessments undertaken and their associated powers. (by end of September '09)

3.8 The LSCB should develop and maintain a service directory for all agencies clarifying pathways for referral and escalating child safeguarding concerns to a higher level if needed. The directory should include information about the following:

a. Clear guidance for other agencies making referral and care pathways simple and clear;

b. Guidance on how to proceed if a second opinion is needed (for example if professionals are not satisfied with the outcomes of an initial mental health assessment).

(by end of December '09)

3.9 The LSCB should, through its Quality Assurance sub-group (or other quality assurance processes):

a. Monitor the ethnic, cultural, linguistic and religious dimensions of local safeguarding practice through for example, the sampling of assessments, anonymised recording and case files and so on;

b. Monitor the formal recording of 'on site' assessments involving safeguarding concerns and whether they have been shared appropriately with other professionals who have a need to know, within 24 hours.

(by end of December '09)

Kingston Primary Care Trust (PCT) Health Visiting & GP Services & Kingston Hospital NHS Trust

3.10 **Kingston Hospital NHS Trust** should lead in the production of leaflets and web-based information for prospective parents and carers outlining the statutory and professional obligations of obstetric, midwifery, health visiting and paediatric staff to refer to Kingston Safeguarding Service, where there is or is likely to be a conflict of interests between welfare and health needs of children and their parents/carers.

- The information should draw on the already devised and implemented guidelines for expectant mothers who are repeatedly non-compliant with treatment.

- The leaflet could act as a pilot/template for London wide, regional or National roll out. (by end of December '09)

3.11 **Kingston Hospital NHS Trust** should review its supervision policy for community midwives to ensure that they are properly supported when working with mothers where there are or might 'safeguarding' concerns. In particular the supervision policy and practice should reflect the need to flag-up and support midwives working with situations where there is:

a. Persistent non-compliance with advice and treatment;

b. Aggressive, hostile or obstructive behaviour by parents/carers – such that the midwife is unable to do his/her job;

c. There are or maybe health & safety issues for ‘lone working’.

(by end of December ’09)

3.12 **Kingston Hospital NHS Trust** Perinatal Mental Health Midwife to be appointed to co-ordinate services for maternal mental health. (Actioned);

The primary purpose will be to develop referral and care pathways and support for expectant mothers who have mental health concerns. The role therefore should be linked to recommendations 2 & 3 for South West London & St Georges NHS Trust (see below)(by end of September ’09)

3.13 **Kingston Primary Care Trust (PCT) Health Visiting & GP Services** Devise and implement guidelines outlining the process for

a. Expectant mothers who are repeatedly non-compliant with treatment, in line with London Safeguarding Children’s Board Policies (2007). Guidelines must include a multidisciplinary discharge planning meeting, to be held at the earliest opportunity, involving all relevant professionals (Achieved) and/or;

b. When and how to request a strategy meeting and when to seek legal advice, in line with London Safeguarding Children’s Board Policies (2007). (Achieved);

c. Parents/carers who are repeatedly non-compliant with treatment, in line with London Safeguarding Children’s Board Policies (2007). (Achieved).

3.14 Health Visitor to raise maternity concerns notification at child protection supervision. (Achieved)

3.15 Feedback outcome of review and recommendations to staff via clinical governance sessions.

Ensure issues around domestic violence, non-compliance and refusal of treatment are highlighted in Trust training programmes and link to/complement LSCB Inter-agency training. (Partially achieved – complete end of September 2009)

3.16 Health Visitors and GPs to attend single and inter-agency specific mandatory training in regards to working with families where domestic violence is a possible risk factor for abuse. (Ongoing)

3.17 Any babies discharged from maternity, which remain under the care of midwives and require re-admission should be referred to the Paediatric Registrar for assessment in Accident and Emergency. The GP and the Health Visiting Service need to be aware of this process. (Actioned)

3.18 Kingston Safeguarding and Prevention Services and Kingston Primary Care Trust to update their Domestic Violence Policies which enhance safeguarding procedures. (Achieved)

Children’s Social Services

3.19 A workshop/training session should be put on for Children’s Emergency Duty Team staff to consider the outcomes and lessons from this serious case review (and others as appropriate). - (by end of September ’09).

3.20 Routine notification of concerns to Children's Emergency Duty Team where the suspected victim is pregnant, a child under 12 months or the subject of an enquiry under Section 47 Children Act 1989 should be monitored. The notification should include an indication of the expected action by Children's Emergency Duty Team staff if the pregnant mother or child comes to notice. - (by end of September '09).

3.21 (Referred) Pre-birth safeguarding concerns should result in a strategy (*or other)* meeting involving relevant agencies as soon as practicable. The Kingston LSCB procedures regarding allegations of domestic abuse now provide such guidance.

However, other concerns (such as persistent non-compliance with medical advice) which endanger the health of the mother and unborn baby should as a minimum provoke such a meeting, the main purpose of which should be to:

a. Devise a collective behaviour management plan;

b. Ensure all services are alerted in the event of an emergency and develop plans as appropriate for contingencies;

c. Ensure non-medical personnel understand current and potential medical risks and terminology;

d. Where the referral falls below the threshold for child protection action, the meeting should consider the need to appoint a Lead Professional (not necessarily a social worker) who can co-ordinate the collation and provision of information

   The appointment and role(s) of Lead Professionals in such circumstances should be the subject of negotiation between relevant agencies, but as a minimum should attract oversight and supervision by experienced and qualified staff.

   - (by end of September '09).

3.22 Children's Social Workers and Practice Supervisors must report all newly referred cases of pregnant women and children under 12 months old suspected to be victims of domestic violence to the Team Manager (or Strategic Manager in the Team Manager's absence) within 24 hours of receiving the referral.(Achieved)

3.23 The Team Manager of the Safeguarding Service must immediately review and re-format the feedback from the maternity concerns meeting in order that actions and lead responsibilities can be easily identified and prioritised. (Achieved)

South West London & St Georges NHS Trust

Mental Health

3.24 Ensure that Trust record keeping standards are applied, training is provided, and regular case file audits undertaken. (Ongoing)

3.25 Ensure through training that Liaison staff are aware of the policy and guidance to be followed where there are concerns about child safety, where support and advice can be obtained and when referrals should be made to Children Services - (by end of September '09).

3.26 Ensure that mental health staff are familiar with the correct process if asked to participate in a serious case review (i.e. following guidelines as given in "Working Together To Safeguard Children" and the Trust Individual policy) using the Pan-London Toolkit - (by end of December '09)

3.27 Any on site mental health assessments that are undertaken should be formally recorded and shared with relevant professionals within 24 hours especially where they relate to the possible safeguarding of a child. (Actioned) (*see above LSCB Rec 3.9 b.)

Metropolitan Police Service Specialist Crime Directorate 5 Recommendation

3.28 It is recommended that the Specialist Crime Directorate 5 Child Abuse Investigation Command must remind officers that if during an investigation new information comes to light of domestic violence within a family the local Community Safety Unit (CSU) must be contacted in order that:

a. Checks are carried out with the CSU.

b. A discussion takes place to consider whether this is an allegation of crime and how best to record this information.

(Achieved)