

Executive summary of the Serious Case Review in respect of a Child known as Child T

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Introduction

This Executive Summary forms part of the Serious Case Review undertaken by Durham Local Safeguarding Children Board as the result of the death of Child T who was four months old when he died in 2008.

It was conducted in accordance with Working Together to Safeguard Children 2006, which was in force at the time, which required that Local Safeguarding Children Boards undertake a Serious Case Review in accordance with Chapter 8 of that statutory guidance in the following circumstances:-

“When a child dies and abuse is known or suspected to be a factor in the death, local organisations are required to consider immediately whether there are any other children in the family at risk of harm who require safeguarding (e.g. siblings, or other children in an institution where abuse is alleged). Thereafter, organisations should consider whether there are any lessons to be learned about the ways in which they work together to safeguard and promote the welfare of children. Consequently, when a child dies in such circumstances the Local Safeguarding Children Board should always conduct a serious case review into the involvement with the child and family of organisations and professionals.” (Working Together 2006).

A full review was carried out and a report known as an overview report was prepared in line with the requirements of Working Together. It looked into how local agencies worked together and whether there were any lessons which they needed to learn. As this overview report gave very detailed information and could lead to the identification of individuals, in line with current Government guidance in force at the time, that report was submitted to Ofsted for an evaluation, but would not be made public. Ofsted evaluated the report as good. The Local Safeguarding Children Board considered the overview report on 12th May 2009 and accepted all of the recommendations.

However, Local Safeguarding Children Boards, at the time this was written, did publish an executive summary, which was required to be anonymised, to protect the identity of family members, once any possible legal and other proceedings have been concluded. The Local Safeguarding Children Board approved this Executive summary, but the publication of this has been subject to a considerable delay to await the outcome of Police enquiries. These were dependent on the opinion of expert medical professionals, and there was a considerable wait for the expert opinion. The holding of the Coroner’s Inquest finally took place in the summer of 2011

This summary gives a brief overview of the case, what was found and what was learned, and the recommendations both for the individual agencies involved and for the Local Safeguarding Children Board itself. All of the recommendations have now been completed.

The review was carried out by an Independent Chair and Author and was also independently overseen by a further Independent person, as was required to meet Government requirements.

Child T and his family were known to Health before his death and also to the Police and the Local Authority Children's Services after his death. Each of these three agencies undertook a review of their involvement which was submitted to, and considered by, the Serious Case Review Sub Committee as part of the preparation of the overview report.

The following are the terms of reference which were agreed for this review;-

1. To confirm the agencies that provided services to Child T and considers representation on the panel /independence/expertise.
2. Identify which agencies will be required to undertake a management review.
3. To identify the most important issues to address in trying to learn from this specific case.
4. Confirm that immediate action has been taken to learn the lessons which have already been identified.
5. Agree process and how relevant information will be best obtained and analysed. This will include which records are to be secured and who is to be interviewed.
6. Agree the time period over which the events are to be reviewed to help better to understand the recent past and present?
7. Agree to consider the particular impact on Child A, Child T's brother
8. Confirm the manner and extent of the family's involvement in the review. This will include the issues regarding the need for an interpretation service.
9. Agree how should family members be informed of, and contribute to the review, and who should be responsible for facilitating their involvement?
10. Consideration of other parallel investigations of practice (–And if so,) and how can a co-ordinated or jointly commissioned review process best address all the relevant questions.

11. How should the review process take account of a Coroner's inquiry, and (if relevant) any criminal investigations or proceedings related to the case? How best to liaise with the Coroner and/or the Crown Prosecution Service?
12. Consider the management of public, family and media interest before, during and after the review?
13. Does the Local Safeguarding Children Board need to obtain independent legal advice about any aspect of the proposed review?
14. Confirm how family members are to be identified in the report.
15. Consider the particular ethnic, cultural, language and disability issues in this case.

Background information

This Serious Case Review concerns Child T, a baby of Eastern European origin, who was born in 2007 and who died in 2008, aged just 4 months. This Serious Case Review is slightly unusual for two reasons.

The first is that it is not the actions of the agencies before Child T's death which have been the focus of this review, but their actions after his death. The actions and omissions of the agencies had a significant impact on Child T's brother, Child A, who was born some 8 months after Child T's death, and on his parents.

The second factor is that although abuse was suspected in respect of Child T, at the time the report was considered by Durham LSCB in 2009, no charges had been brought and no cause of death determined. Although two adults were arrested and questioned about his death, the Crown Prosecution Service advised that no charges should be brought. In the summer of 2011, the Coroner recorded an open verdict, reflecting the findings of the medical experts that Child T died of a traumatic brain injury.

Child T's father is of Eastern European origin, and he moved from his native country to England in 2007 as an economic migrant looking for work. Child T's mother, who was pregnant at the time and who is also from that same country in Eastern Europe, came on holiday to County Durham to visit her partner, Child T's father, later on in 2007. It is understood that Child T's mother had planned to return to Eastern Europe to have her baby but went into premature labour and Child T was born in a hospital in County Durham some eleven weeks early.

As well as being premature, Child T was born with a congenital condition which meant he could become very ill, and possibly suffer serious damage to his brain and eyes. Child T required a significant level of medical treatment for his condition, and was a very vulnerable and sickly baby. He needed to stay in hospital for some 6 weeks after his birth, and then went home with his parents, and continued to be regularly monitored by health professionals.

Some 11 weeks after Child T went home, his parents reported that Child T became very ill at home and he was taken to hospital where he was pronounced dead.

When the post-mortem was carried out he was found to have minor injuries, and the post-mortem was inconclusive. A further defence post-mortem was carried out and this was also found to be inconclusive. However, the following was found:-

- Bleeding to the brain cavity which consisted of watery blood
- Haemorrhaging behind both eyes, more severe in the left eye, and both eyes had congestion of the optical nerve
- A growth on the rib/vertebrae.

This latter finding was found some three months later to be the result of a fracture which had happened some 2-3 weeks before Child T's death.

Further forensic tests were arranged.

Unfortunately, the Police failed to communicate the suspicions regarding the findings to the Local Authority's Children and Young People Specialist and Safeguarding Services as should have happened on three occasions, when Child T died and injuries were found, again when the suspicions were raised following the post-mortems, and finally when a non-accidental injury was diagnosed. The Local Authority had been advised of Child T's death by the hospital where Child T died but not of any suspicious circumstances. Two of those Local Authority staff did make errors when dealing with initial information shared but this probably did not have a significant impact on the outcome for Child A and his parents.

The Police Family Liaison Officer, who was supporting the family, became aware shortly after Child T's death that Child T's mother was pregnant, but he was not aware of any possible suspicions about Child T's death. Information was not satisfactorily shared between the Investigating Officer and the Family Liaison Officer, which resulted in neither Police Officer having the full picture.

In respect of Health, the two Consultants were aware that tests were ongoing to exclude the possibility of non-accidental injury, and were aware that Child T's mother was pregnant. They did not discuss the case with the Designated Doctor or Named Nurse which might have triggered a referral to Safeguarding and Specialist Services.

Finally, some 7 months after Child T's death, when there was still no conclusive cause of death, the Investing Officer, on learning of Child T's mother's pregnancy, instructed the Family Liaison Officer to submit a Juvenile Concern form to Safeguarding and Specialist Services, so that they "could offer support with the new baby." It is extremely unfortunate that this was not done until immediately before Child T's mother gave birth to her second child, Child A.

The relevant information was finally passed onto Safeguarding and Specialist Services, by co-incidence, on the day Child T's mother gave birth to Child A. The information that was shared with Safeguarding and Specialist Services and Health by the Police at the meeting that took place that day was that a possible non accidental injury had been found on Child T after his death and that there were possible suspicious circumstances surrounding his death.

As a result, Child A was removed from his parents on the day he was born with no possibility of planning, assessment and preparation. It is clear that this significant delay in information sharing gave no time for any consideration of any alternatives to this course of action.

The removal of a baby at birth happens very rarely and only in the most extreme circumstances. It must have had an immeasurable impact on Child A and his parents. Although his removal may well still have been deemed to be necessary even if the information had been shared before his birth, it would have meant that much more assessment and planning would have taken place.

Findings of the Serious Case Review

As said before, this review is somewhat unusual as it is the actions of the three agencies involved after Child T's death which has been the subject of the review, due to the impact it had on Child T's brother, who was born some eight months after Child T's death.

It was therefore a clear focus of the review to understand how this series of events occurred and why and how this could be avoided in the future. It is important to say that the extreme seriousness of this has been fully recognised by each of the three agencies involved, each of which have co-operated fully with the review and have been anxious to learn from the process. The review process itself has been challenging and has been a real opportunity to ensure lessons are learned. Early key lessons have already been acted upon.

Child T's parents also expressed the desire to assist the review, both so that they can understand what happened but also from the wish to assist the agencies in their learning. They made a significant contribution to the review, and the Local Safeguarding Children Board is grateful for this.

It is clear that significant and serious errors were made in the handling of this case, particularly by the Police in not passing on vital information that there was a suspicion in relation to the cause of death. There were also some failures on the part of Health and Safeguarding and Specialist Services. This is accepted by all of the agencies.

There were several opportunities when different courses of action could and should have been taken, which would have led to proper planning for Child A's birth.

Some areas of good practice were also identified. It is unfortunate that the impact of the serious failings in the handling of the case overshadowed the good practice for all of the agencies.

It is important to stress that it appears clear from the review that Child T's death in what may be suspicious circumstances could neither have been prevented nor predicted. Child T was a vulnerable baby medically, as a result of his congenital condition and it was known that his condition could prove to be fatal. This condition complicated the investigation following his death.

Recommendations for action

The recommendations of the individual agency management reviews are as follows:-

Within Durham Constabulary

1. Durham Constabulary will implement the new 'Sudden & Unexpected Death in Infancy' Policy and Procedures by 01/05/09.
2. The force will review the training given to Senior Investigating Officer, Investigating Officer, Family Liaison Officer and detectives to ensure it contains guidance on the safeguarding of children and young people, particularly with respect to their responsibilities in relation to the management of risk.
3. Investigating Officers will personally brief Family Liaison Officers in relation to child protection issues and it will form part of the Family Liaison Officer terms of reference. The Family Liaison Officer log will be reviewed and signed on a regular basis. (At least fortnightly)

Within Durham Safeguarding and Specialist Services

1. Review of what “monitoring” means within Safeguarding and Specialist Services and develop guidance and procedure for cases with safeguarding element.
2. Information sharing points to be established with key players from involved agencies in cases where information is being awaited, prior to action being taken.
3. When poor practice has been identified by a service area, to ensure consideration is given to providing information to other services which may have been affected. When Service Managers have received information regarding an issue of poor practice from another service area, to ensure the relevant checks / issues are carried out and recorded as such.
4. That Durham Local Safeguarding Children Board to issue a protocol for sharing criminal lines of enquiry appropriately where safeguarding issues maybe involved.

Within Health

1. Co Durham & Darlington NHS Foundation Trust should check and if necessary amend the record keeping policy to ensure that:
 - i) all staff complete signatory sheets
 - ii) staff record contact and interactions of parents with their children.

The policy should be recirculated to all staff.

2. Where staff are aware of investigations to exclude a Non-Accidental Injury in the sibling of an unborn baby there should be discussion with the Named Nurse or Designated Doctor to establish what action should be taken.
3. Consideration should be given to re-establishing a Liaison Health Visitor to facilitate links between hospital and community staff and ensure an assessment is undertaken of the home prior to discharge of a baby from the Neonatal Unit.

These have all been accepted by the Local Safeguarding Children Board.

Additionally, the following recommendations are made by the Local Safeguarding Children Board

Within Durham Local Safeguarding Children Board

1. Consider making representation to the Department for Children, Schools and Families that when Working Together is re-written, there should be further clarification given to when Serious Case Reviews should be carried out to include cases where it is the subsequent actions of agencies immediately following a death which causes concern as to how agencies have worked together.
2. Agencies should consider whether they have in place systems to support staff who have been significantly affected by the conduct of a case.
3. The Local Safeguarding Children Board to consider the heightened requirements now in completing Individual Management Reviews and Overview Reports and considers how to address the additional demands post-Laming.
4. Prepare information in a range of formats for families involved in a Serious Case Review.
5. It is recommended that the LSCB reviews its current procedures in respect to the securing of records following the death of a child in suspicious circumstances.
6. Whilst appreciating it is outside the timescale of the Review period, the Local Safeguarding Children Board will write to the Department for Children, Schools and Families to highlight the lack of availability of medical experts nationally, given the impact this delay has had on planning for Child A.

Conclusion

The death of a child is always a tragic event, and Durham Local Safeguarding Children Board has been keen to learn the lessons which have been highlighted in respect of how the agencies worked together after Child T's death. The process of the review provided real opportunities for learning and has resulted in changes in practices and policies, which should ensure that the circumstances encountered in this review do not happen again.

Gill Rigg

Independent author

7th September, 2011