Windsor and Maidenhead
LOCAL SAFEGUARDING CHILDREN BOARD

Serious Case Review

EXECUTIVE SUMMARY

Services provided for OY and EY and members of their families during the period January 2008 - February 2011

Windsor and Maidenhead LSCB Independent Chair and Serious Case Review Panel Independent Chair — Donald McPhail

Serious Case Review Overview Report Author — Keith Ibbetson

1 Background to the SCR and the reasons for carrying it out

1.1 Between April and November 2011 Windsor and Maidenhead Safeguarding Children Board (LSCB) conducted a Serious Case Review (SCR) of the services provided to two children who are referred to as OY and EY. When he died in March 2011 EY was aged 11 months and his brother OY was nearly two. EY died as a result of head injuries which are currently the subject of a criminal investigation. OY is the subject of care proceedings.

1.2 The SCR was carried out in order to fulfil the requirements of Chapter 8 of the statutory guidance *Working Together to Safeguard Children* [1] and the Berkshire Local Safeguarding Children Boards Procedures. [2] The LSCB is required to conduct a SCR when a child has died and abuse or neglect are suspected to be a factor in the death. Initial medical opinion indicated that this was the case and the findings of the post-mortem enquiry confirmed this. The circumstances required a SCR. The children normally lived with their mother in the borough of Windsor and Maidenhead. It therefore fell to the Windsor and Maidenhead Safeguarding Children Board to undertake the SCR.

1.3 The decision to hold the SCR was made by the Independent Chair of the LSCB on 30 March 2011. The review covers the period from January 2008 until the death of EY. This review period was chosen to include all of the significant involvement of agencies with child protection responsibilities in the lives of the children. The decision to conduct a SCR was also taken in the light of the following knowledge:

- a number of agencies and professionals with child protection responsibilities had provided services for the children and family
- EY had been looked after by the local authority until the age of seven months although the case was closed by the local authority three months before his death
- EY's parents had initially indicated that they wished him to be adopted

[1] HM Government, *Working Together to Safeguard Children – 2010.*
[2] http://berks.proceduresonline.com/chapters/p_ser_case_rev.html

- a number of professionals had noticed bruising and scratches to EY in the weeks before his death.

EY's older sibling OY had not been looked after. Neither of the children had been the subject of a child protection plan at any point.

1.4 The findings of the SCR and the multi-agency action plan were accepted by the LSCB at its meeting on 16 November 2011. This is the Executive Summary of the findings of the SCR. The SCR overview report has also been published. Information that is judged to be considered potentially harmful to the surviving brother of EY has been removed from the published version of the full report.

2 Arrangements for the SCR

2.1 The SCR reviewed the work of the following agencies who were involved with the family during the period up to and including 2008. All are based in Windsor and Maidenhead or are members of the LSCB because they provide a significant range of services to children and young people in the borough:

- Berkshire East Community Health Services (which provided the health visiting service)
- Primary Care (covering the services provided by three GP practices)
- Heatherwood and Wexham Park Hospitals NHS Foundation Trust
- Royal Borough of Windsor and Maidenhead Council
    - Safeguarding Services [3] (which provides local authority children's social care services)
    - Services for Families (which provides and commissions Children's Centre services and other family services)

2.2 Under the SCR arrangements all of these agencies were asked to review their records, produce an internal chronology of their involvement, interview key staff and provide an individual management review. The authors of individual management reviews were senior staff with expertise in children's safeguarding or independent authors.

[3] This service is referred to as 'children's social care' in the body of the report

2.3 Additional information was also provided to the SCR by the following agencies which had only brief or limited involvement:

- South Central Ambulance Service
- Combined Legal Services (which provides legal advice to social care staff in Windsor and Maidenhead and is hosted by Reading Borough Council)

The mother's school records contained some very limited information which was taken into account by the SCR. No faith, voluntary or community groups were identified as having been involved.

2.4 The review was conducted by a SCR panel which included senior representatives of participating agencies with expertise in safeguarding children and detailed working knowledge of the professional standards relevant to all of the services involved. The SCR panel was chaired by the independent chair of the LSCB. The SCR overview report was prepared on behalf of the LSCB by Keith Ibbetson. Both the SCR panel chair and the report author are independent of the agencies involved and have expertise in children's safeguarding and substantial experience in conducting Serious Case Reviews. The other members of the SCR panel were:

Organisation	Designation
NHS Berkshire East	Designated Paediatrician
Royal Borough of Windsor and Maidenhead Council	Head of Services to Children and Young People
Royal Borough of Windsor and Maidenhead Council	Head of Safeguarding and Specialist Services
Thames Valley Police	Detective Chief Inspector
Thames Valley Probation Trust	Senior Probation Officer,
Berks East Community Health Service	Assistant Director (Children)

The work of the SCR panel was supported by the Windsor and Maidenhead Safeguarding Children Board Manager and the LSCB Secretary. A health overview report was prepared by the Designated Nurse for Safeguarding on behalf of NHS Berkshire which commissions the health services involved with the family.

2.5 The purpose of the SCR is set out in *Working Together* as follows:

- to draw together a full picture of the services provided for the children and their family
- to establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- to identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result
- to improve intra-agency and inter-agency working and better safeguard and promote the welfare of children

2.6 Given the specific circumstances of the case the terms of reference of the SCR asked it to consider whether lessons could be learnt in the following areas:

- historical information on the family members about factors that may have impacted on the parenting capacity of the mother or the father
- the quality of assessment of circumstance relating to the children and their family
- factors that helped or hindered the engagement with the family;
- how well agencies identified and responded to children's injuries and other indicators of harm
- the extent of, and professional understanding of, the support from the extended family
- the advice that was given and the services offered to the parents concerning adoption issues
- risk factors in the family known to agencies during the period under review
- whether staff and managers dealing with the family had the requisite skills, knowledge and experience to respond to the circumstances presented by the family
- whether sufficient attention was given to issues relating the reunification of EY and his mother following the period when he was in foster care

Given the circumstances of the death of EY the terms of reference asked the SCR to consider whether his death could have been prevented.

3 Family involvement in the SCR

3.1 The SCR panel agreed that because of the concurrent criminal investigation into the death of EY it would not be possible to involve the mother or the children or other family members because of the risk of prejudicing the criminal investigation and trial. The LSCB will keep this decision under review and will seek to obtain the views of family members about the services that were provided to the family when it is possible to do so. Any further learning arising from this will be considered by the LSCB.

4 Key events in the case history

4.1 Only very limited information about the family history of the mother and father was obtained by agencies. There is no information in any agency record to indicate any concern about abuse or poor parenting of children in the family history of either of the parents. The mother and the father were in a relationship. There was a considerable age difference between them. The father stated that there was no intention for the relationship to be permanent or for the couple to have children.

4.2 The mother gave birth to the first child in the family at the father's home, with no medical or nursing attention. She was aged 21. She had received no antenatal care and stated that she did not know that she was pregnant. She has no recorded history of mental illness, learning disability or drug misuse. The mother said that she had suspected that she was pregnant about a week before the birth, but did not tell anyone or do anything about it. The child's maternal grandparents were notified about the birth of OY by the hospital soon after the birth. Initially the parents considered relinquishing OY to be adopted but they very quickly changed their minds and took him home.

4.3 Despite the unusual circumstances of the pregnancy and the concerning circumstances of the birth only very limited assessments were undertaken by midwives, health visitors and the local authority

social worker. There were never subsequently any significant concerns about the care provided to OY.

4.4 EY was born in similar circumstances to his brother almost a year later. By this time the mother lived in her own flat. On this occasion the mother admitted suspecting that she was pregnant but she did not tell anyone or seek any medical attention. The father said later that he suspected that the mother was pregnant, but that she denied this. EY's parents wanted him to be accommodated by the local authority and said that they wanted him to be adopted. His father maintained this view consistently. Members of the mother's family were not informed about the birth of EY until he was nearly seven months old.

4.5 The mother stated that she was ambivalent about relinquishing EY for adoption. He lived with foster carers for nearly seven months during which time he was noted to be a healthy child who developed normally. During this period the mother had adoption counselling with the aim of enabling her to come to a properly considered decision about EY's future. Little progress was made by the local authority in implementing the planned adoption. EY's father only saw him once during this period, at a meeting to plan his placement. EY's mother saw him twice during the first five weeks of his life, on both occasions this was linked to planning and review meetings held about him. During the next month she visited him on seven occasions. This was the only time when there was any significant contact between the mother and EY prior to her decision to look after him. In the following 18 weeks she visited him only twice, with gaps of almost 10 weeks between the visits.

4.6 When EY was 28 weeks old the social worker informed the mother's family about the birth of EY. The aim of this was to assist in progressing the proposed adoption, but the local authority also believed that the mother and her family could provide a suitable home for EY. At this point the mother and her family decided that she should look after him. After a short series of visits by the mother to his foster home, EY was placed in his mother's care. The visits were only observed by the foster carer.

4.7 There were no grounds for the local authority to prevent the mother from assuming care of EY, but the complexity of the background and the evidence that the mother had shown very little positive interest in EY indicated the need for careful monitoring of his health and development and the care that he was provided after his placement with his mother. At this point there should have been a coordinated child in need plan linked to a similar plan for his health needs. The local authority closed the case after two visits and the health visiting service offered only its core service i.e. the mother was left to take EY to health clinics and to seek advice from her health visitor or GP if she wished.

4.8 Four weeks after he moved to live with his mother, on her final visit, the social worker noted scratches on EY's face. The social worker accepted the mother's explanation that these scratches had been caused by EY's brother. This was a concerning presentation which might have been an indication of poor parenting or abuse.

4.9 Four weeks after this EY's GP noted bruises on his face and head while he was undertaking a developmental check. When EY's mother was asked about this she stated that these had been caused by his older brother. At this point it was also noted that EY's weight had not increased since he had last been to a child health clinic. The GP did not realise that this coincided with the period when he had been in the care of his mother because he did not have access to his medical records and he did not notice the references to this in EY's Personal Child Health Record.

4.10 Over the following eight weeks staff at a children's centre noted scratches and bruises on several more occasions. The mother had deceived the staff and other parents at the centre by giving him a false surname and telling them that EY was in fact the child of her cousin. She claimed the bruises were caused by his four year old sister, a child who did not exist. Other parents pointed out the bruises and also expressed concern about EY. Professionals found the injuries concerning, but they did not refer them to the local authority to investigate.

4.11 When the children's centre sought advice from the local authority the centre coordinator spoke to an unqualified member of staff without realising this. She was unhappy with the advice given, but did not challenge it. The systems in place in the local authority for screening calls were not clear to other professionals.

4.12 The day before he was admitted to hospital with the very serious injury that caused his death, EY was seen by a health visitor in a child health clinic. She had not met EY or his mother before. The health visitor noticed bruises on his face which the mother said had been caused by a fall the previous day. The health visitor was concerned about EY and noted her intention to speak to his allocated health visitor. Despite the very limited time that she had with EY the health visitor had enough information to have made the decision to refer EY to the local authority. At the very minimum she should have sought the advice of the health trust's named nurse for safeguarding or another senior colleague.

4.13 When he was brought to hospital EY had bruises on his face, head, chest, back and legs. Doctors recognised that he had suffered a very serious head injury. The post-mortem findings show that EY's death was caused by this injury. They also revealed that EY had suffered a number of fractures that predate his death by at least two weeks. It is not possible to date these injuries more precisely so some or all of them may be older than this.

4.14 However, taking only the two week period before he suffered the injuries that caused his death the agency records list three episodes in which bruising was noted or discussed. None of these incidents was reported to the local authority. If that had happened or EY had been referred for a paediatric assessment the bruises would have been investigated. Given EY's age and vulnerability it is very likely that a full child protection medical examination would have been undertaken. In the circumstances this would very likely have included a skeletal survey (an x-ray of the whole body). This would in turn have very likely identified the older fracture injuries and this would have led to action being taken to protect EY.

5 Conclusions of the SCR and key lessons learnt

5.1 The conclusions of the SCR are that 1) over the long term the

potential risks to EY were underestimated 2) when he moved to live with his mother he should have been closely monitored because of the concerns about the circumstances of his birth, and his mother's failure to visit him for long periods when he had been looked after 3) in the two weeks before his death professionals missed opportunities to intervene which, if they had been taken, are very likely to have led to the detection of serious injuries and are very likely to have prevented his death.

5.2 There were a number of missed opportunities to identify and assess the bruising observed on EY. These presentations were highly suspicious. EY's age and circumstances marked him out as being extremely vulnerable. The professionals involved should have responded differently and the bruises should have been reported to the local authority so that child protection enquiries could be undertaken. At the very least professionals should have taken advice from a member of staff or a professional advisor with expertise in child protection or referred EY for a paediatric assessment.

5.3 Taking the case history as a whole there are important lessons for the work of organisations work to safeguard and promote the welfare of children. These relate to 1) the training, skills and knowledge of individual professionals and teams of staff who were involved 2) the wider organisational arrangements that existed within agencies and 3) working arrangements between agencies and the sharing of information.

Concealed and denied pregnancy

5.4 Staff and professionals in all the agencies involved failed to recognise the significance of concealed or denied pregnancy. When there has been a concealed or denied pregnancy the circumstances surrounding it need to be recorded and investigated in detail by midwives, health visitors, GPs and social workers and all other professionals who come into contact with the children and parents. This should always include consideration of the psychological and psychiatric status of the parents.

5.5 When a pregnancy is denied or concealed or a woman presents at a very late point in her pregnancy for antenatal care it is usually the

result of parental learning difficulty, drug misuse or mental illness. These were not features that were present in this case and this is one of the reasons why there was less concern than there should have been. In these unusual circumstances a detailed assessment should still have taken place.

5.6 Communications between midwifery services and health staff such as GPs and health visitors were not sufficiently detailed and specific. They did not consistently make clear the concealed nature of the pregnancies and the lack of antenatal care that the mother had received. This contributed to the fact that GPs and health visitors did not recognise the significance of the history.

5.7 In this case the mother had two concealed pregnancies and this should have further served to alert the professionals involved to the potential concern. Information about the circumstances of the two pregnancies was not linked together consistently. This reduced the capacity of some professionals to recognise the added significance of a second episode.

Initial and new birth assessments

5.8 The new birth health assessment in relation to OY was very limited and failed to seek out information about the concealed pregnancy or wider family factors that might have impacted on his health.

5.9 The initial social care assessments of OY were of limited value. They also failed to seek out information about the concealed pregnancy or wider family factors. The complexity of EY's circumstances merited a social work core assessment. Although there was no procedure to require this once he was a looked after child, professional judgement should have identified the case as a complex one which merited a fuller assessment.

5.10 Professionals failed to involve the children's father and members of the extended family fully. Better engagement would have improved the assessment of risk and need.

Re-unification of children

5.11 Professionals underestimated the risks associated with the re-unification of a child with parents after a considerable period of substitute care (or as in this case when a parent has never had

responsibility for the child). The developmental needs of the individual child, the meaning for the parents of the individual child and the child's history of attachment need to be evaluated in detail even when there is no obvious indication of risk. There is a valuable body of research which shows that the reunification of children with their parent or parents after a prolonged separation is complex work which needs to be carefully planned and monitored.

The ability of professionals to recognise abuse and comply with child protection procedures and guidance

5.12 There was a lack of curiosity about scratches on the face of an infant. This should have been recognised as an unusual and potentially concerning presentation. The bruises observed by professionals should have been considered as highly suspicious and concerning given the age and vulnerability of the child.

5.13 Professionals in three different settings – the GP practice, the children's centre and a child health clinic – did not comply with the child protection procedures and the training that they had received and did not report suspicious injuries to the local authority social care service. They were faced with a confident and convincing parent who denied having harmed her child and gave explanations that professionals found plausible to different degrees. Professionals need to have the skill and confidence to take the action required to protect children when faced with such circumstances.

5.14 If professionals in the health service are not sure that a referral to the local authority is required then they must consider alternatives such making as referral for an urgent paediatric opinion or taking advice from a named professional or another more experienced colleague.

5.15 Key information about EY was held in his Personal Child Health Record. This included significant history that might have affected the way in which professionals responded, including the fact that EY had been a looked after child for the first few months of his life. The design of that document and the way in which some important information about his history was recorded in it meant that it was not obviously noticeable to staff referring quickly to the record.

Arrangements for transferring and sharing information

5.16 There were delays in transferring and summarising the GP records on some family members. This may have impacted in a significant way on the decisions and actions of professionals. Current arrangements for the transfer of GP records are not fit for purpose in relation to the needs of vulnerable children. The delays that are commonplace mean that the service offered by GPs may be seriously impaired and some children may be placed at risk. There are also often delays in summarising records once they arrive at GP practices. Current arrangements make GPs professionally vulnerable.

5.17 The health visitors who were involved with EY prior to and after his discharge from care did not share all of the relevant information about him with one another and did not ensure that his GP knew that he had been a looked after child. The health care of children who are discharged from being looked after needs to be better coordinated. All of the health professionals who will be involved with a child and its family need to be informed about the relevant history and know which other professionals are involved with the child. The role of the looked after children health team should be reviewed to take this into account.

Capacity of organisations and other organisational arrangements

5.18 The caseloads of health visitors in East Berkshire exceeded national recommended levels and the review found that this limited the time that staff had to make visits, to undertake assessments and to practice in a reflective way. Health visiting teams are also responsible for providing child health clinics in a range of community settings. These are popular and very busy and staff may have only a very limited contact time with each child. Staff working in these clinics have limited access to records about the children they see and rely on the information contained in the Personal Child Health Record.

5.19 Children's centres have been developed rapidly in order to make a range of services accessible to children and their families. The staff working in the children's centre attended by EY and his mother lacked experience in running and managing a service used by large numbers of children and had received insufficient training on

safeguarding children.

5.20 Services such as child health clinics and children's centres have been developed with a view to maximising the accessibility of services to families. This is an important and positive objective of policy and service development. As a result of the SCR it has been recognised that the setting in which staff work can enhance or impair the ability of professionals to recognise risks to and meet the needs of vulnerable children. The same applies to the clinical records and other information systems that are available to staff.

5.21 The social worker who was primarily responsible for EY's case was newly qualified and inexperienced. She was allocated this case because it was believed to be a straightforward piece of work. This underestimated its potential complexity, given the concealment of two pregnancies. Newly qualified social work staff dealing with children's cases require a high level of supervision tailored to their individual level of competence, skill and knowledge. This was absent in this case.

Learning the lessons of the SCR and the implementation of recommendations

6.1 The findings of the SCR and the recommendations that flow from them have been adopted by Windsor and Maidenhead LSCB. The LSCB has produced an action plan that sets out the actions needed, who is to be responsible for taking them and the timescales for completion. Many of these recommendations have already been fully or partly implemented. The LSCB will oversee implementation over the coming months to ensure that lessons are learnt and practice improves. The full detail of these recommendations is set out in the action plan that accompanies this document.