

Waltham Forest Local Safeguarding Children Board

SERIOUS CASE REVIEW EXECUTIVE SUMMARY

Child J K, who died
aged three months



1 INTRODUCTION

- 1.1 For the purposes of confidentiality, this report has been anonymised. MK is JK's mother; JS is JK's father and SK is JK's brother, born on the 10th of February 2006.

Circumstances of the child's death

- 1.2 The circumstances set out below are as reported by JK's parents. Corroboration is available from the point that the emergency services were contacted on the day of JK's death.
- 1.3 On the 24th of September 2007, JK, aged three months, woke at 8.00am, which was normal. He had a bottle feed, and his nappy was changed. His mother returned him to his cot. At 10.00am, JK's mother took him shopping in his pram. They returned at around 11.00am, and he was placed back in his cot, whilst his brother played with his toys. At around 1.00pm, MK noticed that JK had a full nappy. She took him out of his cot to change him and placed him on the sofa, where he appeared lifeless. MK then called an ambulance, and was given resuscitation instructions over the telephone. The London Ambulance Service attended and resuscitated JK. JK was taken to Whipps Cross University Hospital (WXUH), where further resuscitation was attempted. This was unsuccessful.
- 1.4 Prior to the post mortem on the 26th of September 2007, a skeletal survey was undertaken. This showed that JK had several fractures, including to the right side of the skull, a left rib and the right humerus. The fractures were of varying ages, the rib fracture being the oldest.

- 1.5 JK's parents were arrested on the 26th of September 2007, and SK was placed in the care of the Local Authority (LA), under Police protection.

Background to agency involvement

- 1.6 MK came to the United Kingdom (UK) from Slovakia with her parents temporarily in 1998. She attended a school in the London Borough of Hackney (Hackney). She returned to Slovakia when her parents separated, and then returned to the UK with her partner, JS, in February 2005. In August 2005, when she was fourteen weeks pregnant with SK, she attended a General Practitioner (GP).
- 1.7 The family is known to have lived at three, and may have lived at four, addresses in the London Boroughs of Haringey and Hackney and then the London Borough of Waltham Forest (LBWF). They came to the attention of, or used, GP and midwifery services in all three Boroughs; antenatal and maternity services at University College Hospital (UCH); casualty, maternity and neonatal units at WXUH and health visiting services in all three Boroughs. The parents made an application for housing in LBWF in January 2006, but had no known contact with children's social care services or the Police in any of the three LAs.

2 REVIEW PROCESS

Initiation of the Serious Case Review

- 2.1 The Serious Case Review (SCR) Sub-Group of the Waltham Forest Safeguarding Children Board (WF SCB) was convened on the 23rd of October 2007, and decided that the circumstances of JK's death met the criteria for SCR as outlined in Working Together to Safeguard Children 2006.

Membership and conduct of the Serious Case Review

- 2.2 The full Terms of Reference for this SCR are set out in appendix one to this report.
- 2.3 SCR Sub-Group membership was as follows:
- 2.3.1 Jo Olsson (Chair) – Deputy Director of Children Services (LBWF);
 - 2.3.2 Jaynn Taylor – Interim Head of Services for Vulnerable Children (EduAction);
 - 2.3.3 Janette Shaw – Nurse Consultant for Child Protection (Waltham Forest Primary Care Trust (WF PCT));
 - 2.3.4 Christine Sloczynska – Designated Doctor for Child Protection (WF PCT);
 - 2.3.5 Linda Cointepas – Group Manager for Plans, Partnerships and Protection Services (LBWF);
 - 2.3.6 Karen Cooper – Child Protection Coordinator (LBWF);
 - 2.3.7 Mick Thurley – Detective Inspector of the Child Abuse Investigation Team (Metropolitan Police Service);
 - 2.3.8 Theresa McLeary – Named Nurse for Child Protection (WXUH);
and
 - 2.3.9 Marilyn Claydon – Clinical Services Manager (WF PCT).

- 2.4 Initial enquiries showed that the only agency with substantial contact with the family was health, and it was, therefore, determined that an Individual Management Review (IMR) would be conducted within health services. Due to personnel changes, the work was begun by one person and concluded by another. Janette Shaw was responsible for the health IMR. Lucy Erber, Principal Officer for Child Protection and Safeguards Services (LBWF) was to undertake the Overview Report (OR); however, she took up a secondment opportunity before work started, and Karen Cooper was, therefore, asked to produce the OR.
- 2.5 The Chair of the SCR Sub-Group has written to the Local Safeguarding Children Boards (LSCBs) in Haringey, Hackney, the London Borough of Camden (Camden) and the City of London to advise them of the review, and that there will be implications for health colleagues in their areas. The Chair of the SCR Sub-Group also wrote to JK's parents to inform them of the intention to undertake an SCR, with an offer of feedback about the outcome, once the report was completed.

3 CONCLUSIONS AND LESSONS TO BE LEARNED

- 3.1 On the basis of what was actually known to local agencies, no ground existed to justify a referral to social care services, or the initiation of any protective action by means of Section 47 (of the Children Act 1989) enquiries or legal intervention.
- 3.2 From the evidence collated by the health services, there were opportunities for improved information gathering, record keeping and communication that may have led to a different assessment of need, and the provision of additional services.

- 3.3 Assessments in the case were very variable. The pieces of the puzzle were not put together in an effort to establish the story of this child's life, and the expectations of his care. There is a lack of systematic collection of information, analysis and recommendation. Expected standards were not met.
- 3.4 The lack of appropriate information recorded or assessment has highlighted a gap in understanding of thresholds for children in need of additional services. There is no indication from the work carried out that professionals had a sense that the child or family may need additional services, what information would be needed to secure such services or who they might talk to.
- 3.5 Limited consideration was given to this family's mobility, their youth, their first language or their new resident status. Such consideration was affected by the fact that the mother was able to speak adequate English.

4 RECOMMENDATIONS

- 4.1 WF SCB needs to establish the use of the CAF within LBWF by:
- 4.1.1 agreeing and publishing thresholds for CAF;
 - 4.1.2 developing swift and easy referral processes between services; and
 - 4.1.3 ensuring that staff undertaking an assessment are competent to carry out the task.
- 4.2 The LSCBs for all Boroughs concerned need to ensure that their key agencies understand the principles and expectations of recording and transferring information.

- 4.3 LBWF health agencies need to ensure that recording standards are in place, which are quality assured through regular audits.
- 4.4 All agencies need to ensure that policies, procedures and training opportunities make reference to the issues arising from mobility, particularly amongst minority ethnic communities where English is spoken as a second language.
- 4.5 WF PCT needs to consider a protocol around follow-up checks on discharge from hospital, to include weighing and measuring but not exclusively so, the frequency to be decided according to the needs of that particular child.
- 4.6 When children become new patients to a GP, the GP practice must communicate with the HV as part of establishing whether the child is in need of any routine or missed services.

Jo Olsson

Chair - Waltham Forest LSCB Serious Case Review Sub-Group

APPENDIX 1: WALTHAM FOREST SAFEGUARDING CHILDREN BOARD SERIOUS CASE REVIEW SUB-GROUP TERMS OF REFERENCE

**Waltham Forest Safeguarding
Children Board Serious
Case Review Sub-Group**

Terms of Reference

| | |
|-------------------------------|---------------------------------------|
| Author | Jo Olsson (chair) |
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| Date Prepared | 23/11/07 |

Terms of reference for serious case review

JK

1. General

Waltham Forest Serious Case Review Group is an ad hoc group that is convened whenever a child dies and abuse or neglect is known or suspected to be a factor. It may also be convened when a child sustains a potentially life-threatening injury or serious and permanent impairment of health and development, or has been subjected to particularly serious sexual abuse; and the case gives concerns about inter-agency work to protect children. It is responsible for:

- Conducting reviews under Part 8 of the guidance contained in “Working Together to Safeguard Children (2006)”;
- Further responsibilities as set out in the London Child Protection Procedures.

2. Serious Case Review of JK

The Serious Case Review Group met on 23 October 2007 following the death of JK, an infant. The following terms of reference, specific to this serious case review were agreed:

The Group agreed that under Section 19.1.4 of the LSB Child Protection Procedures this case met the criteria for a Serious Case Review.

It was agreed that health will undertake a single agency review as this is the only agency to have had previous involvement with the family in Waltham Forest

The principal officer for child protection, children and families service will produce the overview report based on the report from health to include an analysis from the perspective of newly arrived families and any other information generated by the health review.

The London Safeguarding Children Board's report on the analysis of serious case reviews, identified newly arrived families as being over represented in such reviews. It was agreed therefore, that that expert advice could be requested from that board if the author of the overview report felt this would be useful.

The first draft of the health individual agency management review is to be presented to the Serious Case Review Group by the first week in December 2007.

The report will cover the period from when the mother arrived in this country February 2005.

It was agreed that an independent review was not needed.

It was agreed that any media interest is to be managed between partners with no outside media communications.

It was agreed that no independent legal advice would be required.

It was agreed that the chair of the Waltham Forest serious case review sub group would write to the parents, informing them of the LSCB's intention to undertake this review

It is anticipated that the review will be concluded in advance of the conclusion of both criminal and coroner proceedings. Any feedback to the parents would need to postdate these proceedings.

3. Individual agency management review

3.1 In analysing the involvement with the child and/or family, the individual agency management review shall specifically consider the following areas

- Were practitioners sensitive to the needs of children in their work, knowledgeable about potential indicators of abuse and neglect and what to do if they had concerns about a child?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points / opportunities for assessment and decision making in this case in relation to the child and family?
- Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made?
- Were appropriate services offered / provided or relevant enquiries made in the light of assessments?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- Were more senior managers or other organisations and professionals involved at points when they should have been?

- Was work on this case consistent with the organisation's and the LSCBs policy and procedures for safeguarding and promoting the welfare of children, and wider professional standards?

3.2 When analysing potential learning from the case, the individual management review shall consider the following:

- Are there lessons from this case for the way in which this organisation works to safeguard and promote the welfare of children?
- Is there good practice to highlight as well as ways in which practice can be improved?
- Are there implications for ways of working; training (single and inter-agency); management and supervision; working in partnership with other organisations; resources?

3.3 When making recommendations for action, the individual agency management review shall consider the following questions:

- What action should be taken, by whom and by when?
- What outcomes should these actions bring about, and how will the organisation evaluate whether they have been achieved?

4. The LSCB overview report

4.1 The LSCB overview report will bring together and draw overall conclusions from the information and analysis contained in the individual management review and be produced according to the following outline format.

4.2 Format of the LSCB overview report

4.2.1 The introduction will:

- Summarise the circumstances that led to a review being undertaken in this case.
- State terms of reference of review.
- List contributors to review and the nature of their contributions
- List review panel members and author of overview report.

4.2.2 There must be a factual section that sets out the following:

- A genogram showing membership of family, extended family and household;
- An integrated chronology of involvement with the child and family on the part of all relevant organisations, professionals and others who have contributed to the review process.
- The chronology must specifically note each occasion on which the child was seen.
- An overview which summarises what relevant information was known to the agencies and professionals involved about the parents, any perpetrators, and the home circumstances of the children.

4.2.3 The analysis must examine:

- How and why events occurred, decisions were made, actions taken or not.
- The reviewer may consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events.
- Any examples of good practice which should be highlighted.

4.2.4 The conclusions and recommendations will:

- Summarise what, in the opinion of the reviewer, are the lessons to be drawn from the case, and how those lessons should be translated into recommendations for action.
- Recommendations should include, but should not be limited to, the recommendations made in individual agency management report.

- Recommendations should be few in number, focused, specific, and capable of being implemented.
- If there are lessons for national as well as local policy and practice, these should also be highlighted.

4.3 Action by the LSCB on completion of the overview report

4.3.1 On receiving an overview report, the LSCB will:

- Ensure that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the overview report.
- Translate recommendations into an action plan endorsed by a senior level in each of the organisations involved.
- Ensure the plan sets out who will do what, by when, and with what intended outcome.
- Ensure the plan sets out by what means improvements in practice / systems will be monitored and reviewed.
- Clarify to whom the report, or any part of it, will be made available.
- Disseminate the report or key findings to interested parties as agreed.
- Make arrangements to provide feedback and de-briefing to staff, family members of the subject child and the media, as appropriate.
- Arrange for an executive summary of the overview report to be compiled, which will provide a summarised and anonymised version of the report.
- Agree any urgent action arising from the serious case review that requires immediate action.
- Provide a copy of the overview report, action plan and individual management reports to Ofsted and the Department for Children Schools and Families.