**Serious Case Review Into The Death of Child F**

**Born in April 2001**

**Died in June 2008**

## 1. INTRODUCTION

This is a summary of a Serious Case Review conducted by Sandwell Safeguarding Children Board in accordance with Chapter 8 of "Working Together to Safeguard Children 2006" in order to

- Establish whether there were lessons to learn from the case about the way professionals and organisations concerned worked together to safeguard and promote the welfare of children

- Identify the lessons, how they are to be acted upon and what is expected to change as a result

- Improve inter agency working and better safeguard and promote the welfare of children

In production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality. Sandwell Safeguarding Children Board has balanced the need to maintain the privacy of the child and family with the need for agencies to learn lessons relating to practice identified by the case and has authorised the publication of sufficient information to enable this to take place.

The panel was asked to focus upon the following which formed the Terms of Reference of the Review:

- The response of agencies to provide co-ordinated services to children and families where there are issues of ; - poor attendance at health appointments and compliance with treatment plans and Poor school attendance

- The extent to which there was a coherent understanding between agencies on the threshold for intervention where neglect is a concern
- Review the triggers indicating the need for a CAF meeting and any barriers that may exist that impact on agencies application of CAF
- To what degree was the assessment undertaken by the mental health providers cognisant of the impact of mum's mental health diagnosis on her capacity to parent a child with a chronic disease and manage the requirements of a drug therapy regime.
- Whether the child's in need status was identified, and actions taken in accordance with agreed procedures to secure the necessary support services.
- The extent to which there were gaps in services provided

## 2. Synopsis

The mother of the child suffered mental health difficulties, shortly after birth and subsequently received intensive interventions from the mental health agencies. The child was born with a chronic disease and required a drug therapy regime. When living in the Community there were opportunities missed to co-ordinate the care of both mother and child and therefore key information which would have indicated the need for a more holistic assessment of need and risk was not acted upon.

The signals known by mental health professionals were not widely shared and understood by others. The multi-agency assessment in the latter stages was not as enquiring nor rigorous in its explorations of how mother's mental health deterioration impacted on the child's experience of being parented and other aspects of her well being and development e.g. school attendance.

Non-compliance was a concern of health professionals. Those responsible for the child's health care documented the concerns that some of the child's illnesses were suggestive of non-compliance with prescribed drugs, but did not share this with Children & Young People's Service.

Mother displayed known signals of her deteriorating mental health, in the months leading up to the child's death, but despite attempts at contact, professionals were unable, to overcome mothers reluctance to let professionals into her home.

The child's school attendance remained poor up to the date of her death.
The child became seriously ill whilst at home with mother, taken to hospital, however, shortly after arriving at hospital, was pronounced dead.

A subsequent examination of the home underscored the concerns held by professionals and indicated that mother had been in declining mental health for some time and that this had impacted on her parenting capacity for a child with health needs of their own.

## 3. Lessons Learnt

What emerges from the reading of the IMRs is that professionals failed to "stock take" and consider whether there was full or partial compliance – co-operation or non co-operation. Analysis of child deaths and serious injury through abuse and neglect: What can we learn?, suggests it is helpful to view co-operation on a continuum, representing degrees of co-operation, on one end with "*lack of co-operation, including avoidance of contact and many missed appointments"* at the other.

Whilst mother's mental health and its impact was through no fault of her own, this should not have negated the importance of professionals seeking to understand the impact on the child and the potential for the child to periodically live in an emotionally and physically neglectful home environment. Such an approach does not serve to blame or penalise parents for their illness but rather to assume that the interventions of professionals, where the wellbeing of children is a consideration, establishes the psychological availability of their key carers and importantly, how this impacts on the children as they develop through their milestones. This child's particular health needs made this consideration even more important.

"Think Child" – the importance of all agencies to retain child centred practices particularly when the needs of the adult are significant.

The importance of having a lead professional to co-ordinate multi-agency working.

The need to share information inter and intra-agency.

Clearly understood pathways for triggering multi-agency support for children and their carers, with agreed thresholds by all key agencies.

The role of case recording in ensuring that known information is gathered, analysed and that plans are based on sound professional judgements.

The need to consider the implications for the welfare of children where adults are non-compliant with important drug therapy regimes.

## 4. Recommendations

1. PCT and PCT (NHS) to amend he current information sharing protocol to include "read only" access to the GP electronic patient held records for all GP attached professionals and relevant health professionals

2. SWBHT and PCT (NHS) to undertake an audit of GP booking referral letters to maternity services to check for completeness of information regarding issues of vulnerabilities.

3. PCT, SWBHT, and PCT (NHS) Trust to ensure that polices and procedures on DNA's pertaining to children detail the potential risk factors for the well being of children.
4. Sandwell Mental Health Trust to ensure that where there are issues of non compliance with drug therapy regimes, that polices and procedures for adults who are primary caregivers, detail the potential risk for children in their care.

5. PCT (NHS) SWBHT, PCT and Sandwell Mental Health Trust to record their assessments of the risk factors for the well being of the child(ren) where there are issues of DNA's and/or non compliance.

6. Birmingham and Solihull Mental Health Trust and Sandwell Mental Health Trust to ensure that CPA meetings held to plan for discharge invite attendance from across all the relevant agencies.

7. All agencies involved in the multi agency teams to agree the respective roles and responsibilities of each agency when acting as lead professional and determine the thresholds for referral.

8. Children and young people services to ensure that agreed multi agency plans, arising from CIN processes to be dated and circulated to all those named therein.

9. All statutory agencies to review their existing audit tools to ensure that compliance with record keeping policies are included.

10. That practice guidance for practitioners of all agencies explicitly encourages self definition re: ethnicity and where this is not established for the record to indicate that this is the case.

11. The LSCB to review how the 3rd sector childcare organisations can effectively participate in the Boards work.

12. LSCB to develop safeguarding compliance criteria for use by the Commissioning Unit in all contracts and/or SLA's where services are provided for children, young people and their carers.

13. LSCB to agree with the Commissioning Unit that the safeguarding criteria is included in all future contracts for providers of Services and at the next review for existing contracts.

14. That the LSCB commission the Quality Assurance and Audit sub group to report on the extent to which practice in core assessments has improved as a result of the interagency training provided.

15. Sandwell Homes to-confirm the membership of the single referral panel and detail how safeguarding considerations for those young people considered by the panel are managed and documented and report on how safeguarding is quality assured and monitored as part of contract with 3rd sector providers