SERIOUS CASE REVIEW

Executive Summary

Under Chapter VIII

'Working Together to Safeguard Children'

In respect of the death of

FW

Report by:

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Presented to
Worcestershire Safeguarding Children Board

on

28 January 2013

INTRODUCTION

This Serious Case Review was conducted under the guidance outlined in Chapter 8 (8.5) of the Working Together to Safeguard Children 2010. The purpose is 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;
- 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; and
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

Serious Case Reviews are not inquiries into how a child died or was seriously harmed, or into who is culpable. These are matters for coroners and criminal courts, respectively, to determine as appropriate.

In production of this report agencies have collated sensitive and personal information under conditions of strict confidentiality. The Worcestershire Safeguarding Children Board (WSCB) 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.

A decision to undertake a Serious Case Review was made on the 25 June 2012. The WSCB determined that agencies would secure and review their files from September 2006 until the date of the child FW's death. Agencies were required to compile an Individual Management Review (IMR) to provide an independent, open and critical analysis of individual and organisational practice. The IMRs should identify lessons learnt by the individual agencies, highlight any good practice and include recommendations for single agencies to improve practice. A Health Overview Report was also requested in order to evaluate the practice of all involved health professionals with the intention of focusing on how health organisations interacted together and to produce any additional recommendations if appropriate.

Terms of Reference

In addition to the generic terms of reference contained within the Working Together to Safeguard Children Guidance 2010, the most important issues to address in trying to learn from this case were identified as:

Additional issues for all agencies specific to this SCR:

- What assessment was made by agencies of the parents' substance misuse, notably mother's alcohol dependency? What action was taken in response to this? Was advice sought from specialist alcohol services or a referral made?

- What training have staff involved with the family received in relation to alcohol and drugs misuse?
- 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?
- Are there implications for current policy and practice?
- What action should be taken by whom and when?
- What outcomes should these actions bring, and in what timescales, and how will the organisation evaluate whether they have been achieved?
- Are there any immediate statutory requirements for the notification of concerns?

Agency Specific Issues:

Children's Services (Safeguarding and Services to Children);

- Was the response to referrals, including those that were anonymous, sufficient? Was there a pattern to the referrals, if so was this recognised and acted upon?
- Were any risks to the children fully recognised and were the implications for each of the children considered, given the wide range of ages and hence needs?
- Was the Core Assessment undertaken in 2009 child focussed and did it

address the risks to the children?

- Was an assessment made of S1's role in the family and of the level of responsibility that he assumed?

Education:

- Did the Education staff have any concerns about the presentation of the children or their parents?
- If so what action was taken?

Health and Care Trust:

- How aware were the Health Visitors of either parent's use of alcohol and or drugs? Were any risks identified and acted upon?
- Was consideration given to seeking advice in respect of substance misuse or referring to a specialist agency?
- Was the information shared with other agencies appropriately, including Children's Services and the family's GP?
- What was the reason for the delay in access to Adult Mental Health services in 2007 and was this delay significant?

Worcestershire NHS

- Did the GPs have any concerns about the presentation of the children or the parents?
- What were the arrangements for communication between the GP and other health professionals, i.e. Health Visitors and School Nurses?
- What was the reason for the delay in access to Adult Mental Health services in 2007 and was this delay significant?

Housing provider:

- Were any concerns/complaints received from neighbours/tenants regarding the family which would have significance for the care of the children? If so, what was the response and was this adequate?

SYNOPSIS

A '999' call was received from the parents of FW who reported that FW, their baby, had been found not breathing. The ambulance crew attended the home address and found FW in cardiac arrest. Both parents were present and the mother (FW2) was carrying out CPR which was continued by the ambulance crew whilst FW was conveyed to hospital where full emergency lifesaving procedures were initiated but proved unsuccessful. It was established that FW had been co sleeping with the parents who had both consumed alcohol and controlled drugs (cannabis). A criminal investigation was conducted but the cause of the death of FW could not be ascertained. The findings of the investigation was considered by the Crown Prosecution Service and it was decided not to pursue a prosecution against the parents.

FW was born into an overcrowded and somewhat chaotic and cluttered household with parents, particularly the mother, who regularly drank alcohol to excess and there were indications that cannabis use by the parents also took place. FW's mother has a history of alcohol abuse, suicidal thoughts and overdosing on medication. There is evidence that FW's eldest sibling often took on a caring role of the younger siblings and to some extent of the mother, being very protective of

her. The eldest sibling raised concerns about the mother's drinking on a number of occasions to health professionals, reported domestic disputes between the parents and called for ambulances when the mother overdosed on drugs and alcohol. There were reports of the children being left alone in the house and also playing outside unsupervised.

During the period of this review the family came into contact with a range of agencies and this generated a total of eight incidents concerning the welfare of the children being reported to Children's Social Care which included anonymous reports made to the NSPCC.

Generally the family were viewed by professionals as a compliant and devoted family unit with good emotional bonds and the support of wider family. FW2 was able to deflect difficult questions particularly in relation to her continued alcohol use and concerns around care and supervision of the children. There appeared to be elements of 'disguised compliance' which professionals colluded with by not effectively challenging FW2 in light of historical concerns and significant key events.

LESSONS LEARNT

- There was a failure across agencies to take a holistic view of the family with incidents being treated in isolation rather than any patterns being identified.
- Good information exchange from the police to Children's Social Care and

Health but poor communication by Children's Social Care to other agencies with a failure to make lateral checks upon receipt of referrals or concerns about the welfare of the children.

- Assumptions made by the police and Children's Social Care that health professionals, e.g. GPs, school nurses, health visitors, midwives, routinely share information which is known by one party. This case demonstrates that this is not generally the case.
- Cases were closed by Children's Social Care prematurely with insufficient investigation and an over reliance upon health visitors to monitor the family.
- The risks posed to the children by excessive alcohol consumption and drug-use were not fully recognised or acted upon by professionals.
- An optimistic view of the family was taken by professionals despite indicators of neglect, and a failure to challenge when the mother clearly minimised her alcohol consumption and deflected difficult questions about the care and supervision of the children.
- Concerns raised by the eldest child were not sufficiently pursued with that child and there was no assessment of the impact on that child or on the other children in the family.
- The focus was disproportionately upon the needs of the mother and the focus on the children was lost.
- There was no evidence of any engagement with the father by any professional.
- Whilst information about the dangers of co-sleeping were routinely brought to the attention of the mother, there was no evidence of health visitors seeking information of the sleeping arrangements of FW or the siblings

particularly in view of the overcrowded family home.

GOOD PRACTICE

There were no examples of good practice over and above what was the normal procedure/expectation of agencies or individuals revealed during this SCR.

CONCLUSION

It was normal practice for the parents to co-sleep with all of their children whilst they were babies and whilst professionals routinely drew attention to the dangers of co-sleeping to the mother, there is nothing to suggest that this was reinforced to her, when it became apparent that she drank alcohol to excess and that she had become overweight and indeed was classified as 'obese'. It appears that the father was never advised of the risks posed by co-sleeping. There was therefore a risk to FW as a result of co-sleeping with the parents and possibly FW's death could have been prevented but as the cause of death cannot be ascertained this will never be known. It has therefore been concluded by the Panel that the death of FW could not have been predicted by agencies or professionals.

RECOMMENDATIONS

- ***WSCB requests that all partner agencies review the use of chronologies to inform discussions, assessments and planning for children and their families. This information should then be shared with WSCB with a view to the Board promoting the use of***

chronologies, including multi-agency chronologies, as appropriate.

- ***WSCB to recommend to all agencies that training on drug and alcohol risk assessment is incorporated into training plans for all front line staff.***

- ***The WSCB to incorporate into one of its regular communications to staff in partner agencies the identification of the needs of and support services available for young carers.***

- ***WSCB reviews its Inter-Agency Procedures to ensure the role of fathers and male partners is systematically identified, assessed and recorded by those agencies providing on-going children's health and social care services.***

SERIOUS CASE REVIEW PANEL CHAIR AND MEMBERS

Independent Chair Nicki Pettit (Independent Consultant)

Panel Members

Clinical Service Lead Health Visitor – Worcestershire Health & Care Trust

Consultant Nurse (Designated Professional) Safeguarding Children – NHS Worcestershire

Operational Manager, Support, Guidance and Skills (Connexions)

Programme Manager, Social Care Workforce Reform, Worcestershire County Council

Public Protection Detective Inspector – West Mercia Police

Training Officer – Worcestershire Drug & Alcohol Action Team

Independent Author Gill Baker (Independent Consultant)

ENSURING LESSONS ARE LEARNT

The report findings were ratified by Diana Fulbrook the Independent Chair of the Worcestershire Safeguarding Children Board on 28 January 2013. All Safeguarding Board Members welcomed the report findings and agreed to ensure that all recommendations would be fully implemented within the agreed timescale. Worcestershire Safeguarding Children Board will closely monitor implementation requiring each agency to demonstrate and evidence that lessons have been learnt from this tragic case.

Single Agency Recommendations

A total of 28 single agency recommendations were made which were progressed whilst this Serious Case Review was on going.

An additional 3 recommendations were generated by the Health Overview Report.