Serious Incident Learning Review Summary (SILR 11A)

Reason for the Review

This case was discussed at the DSCB Serious Case Review Sub-Committee on 01/04/11 and it was agreed that a Serious Case Review would not be held as the death was considered by the Police to have been caused accidentally as a result of co-sleeping. The full Post Mortem report has subsequently concluded that child died of pneumonia. It was agreed a learning review would be undertaken to establish whether there were any learning or practice issues which could be applied to similar cases in the future.

Review of the Process

An initial scoping meeting was held on 18.05.11.

All agencies participating in the review were asked to prepare a chronology of their involvement with the family covering the period between May 2010 and 12.03.11 and a background summary of information known about both parents.

Health agencies held a facilitated session before the review meeting to produce a single health chronology and report.

The review meeting took place on 18.07.11.

Agencies Involved in the Review

- Health Visiting Services
- Midwifery Services
- G.P. Practice (s)
- Nottinghamshire Hospital
- Derby Hospital
- Minor Injuries Unit
- Derbyshire Health United
- EMAS
- Derbyshire Healthcare NHS Foundation Trust
- Derbyshire Constabulary
- Nottinghamshire Constabulary
- DCC CAYA
- Probation

Nottingham City and Nottinghamshire LSCB's were informed that the review was being undertaken in view of the involvement of the Nottinghamshire Hospital and Nottinghamshire Police.

Family Background

At the time of death the child was being cared for by Father as Mother had been hospitalised due to a serious illness which resulted in her having a splenectomy.

Father was adopted as a child and also spent brief periods of time in care due to relationship difficulties at home, this area will be covered in more detail later in the report.

Mother is registered partially sighted.

The age gap between parents of 12 years was noted in the process of the review although no conclusion can be drawn. It is understood that the couple were supported by maternal grandparents, little is known about paternal grandparents.

During the investigations following the child's death and the process of the review, it transpired that Father had a significant history of criminal behaviour, substance misuse and a risk to partners and resident children due to him perpetrating serious domestic violence. Father has another child, aged 10 years. He has no contact with this child due to issues of domestic violence.

Significant Events/Facts

Father

The review considered information that Father was adopted as a small child, there did not appear to be anything remarkable about the adoption.

In 1996, Children's Social Care became involved with Father when he was reported by his parents to be sleeping rough and stealing from them. He was also said to be abusing substances and truanting from school.

Father had received professional input from Social Care, an Educational Psychologist and the Youth Justice Service. Following a brief period in a hostel, father returned home, the family withdrawing from services including family therapy.

In August 1995, father was taken to a Nottinghamshire Hospital stating that he had swallowed a razor blade. Investigations did not evidence this. In 1997, Father was again stealing from parents; he was arrested and placed in a hostel in Nottingham. There was no involvement from Social Care at this time. Father continued to offend and involvement by the Youth Justice Team was followed by the Probation Service in 1999.

Probation records show that in 1998/9 father was preoccupied with killing someone with a pen. A report in 1999 assesses father as having personality difficulties, impulsive behaviour, some substance misuse and low self esteem. There is no evidence of mental disorder within the meaning of the Mental Health Act 1983.

In June 2001, Father was arrested and subsequently convicted of arson when he set fire to the sofa at his home. A Pre-Sentence report described Father as having a psychotic disorder. There is no indication as to follow up as the actual report cannot be located. This followed the breakdown of a relationship; his ex-partner and her child were not present at the time of the incident. There was no follow up by agencies in relation to an assessment of risk presented by father to partners or their children. This was a missed opportunity.

During 2007, Father was MAPPA managed at Level 2. At this time he was described as a very disturbed man with a personality disorder who was taking both prescribed and illicit drugs. He had received a suspended sentence for a significant assault on a partner. In December 2007, his MAPPA status was reduced to Level 1. This was due to only one agency, the Police, being involved in his management, not because of a reduction in the risk he presented.

This is a substantial learning point in the review since it would appear that staff across agencies are not clear about the levels of MAPPA management in relation to the risk presented by an individual. This point will be addressed in the recommendation section of this report.

In May 2008, a Substance Misuse Voluntary Agency became involved with father regarding issues around the use of cannabis and the use of heroin in the past.

The history suggests substance misuse from the age of 11 years. At that time Father was living with a woman who had a child.

During the assessment, Father disclosed to the Substance Misuse Voluntary Agency worker that he had put a gun to his mother's head in order to obtain money from her. This matter was not reported to the Police or Children's Social Care and represents a significant failure to follow Safeguarding Procedures. The member of staff concerned is no longer employed by the Substance Misuse Voluntary Agency. This failure clearly represents a significant missed opportunity to raise concerns and put in place protective arrangements in relation to fathers contact with partners, their children, family members and potentially professionals who might come into contact with him.

The Police have information relating to Father's offending behaviour dating back to 1996, including theft, burglary, drug offences, arson and domestic violence. The final incident was in January 2010 when he assaulted the child's mother; he was cautioned for this offence by Nottinghamshire Police. Mother would not have been pregnant at this time.

In summary Father was a man with a very disturbed background with a history of substance abuse, violence and arson. He had been involved with several women who had children. His personality was described as unstable and impulsive. He was reported to have struggled with school and missed periods due to truanting.

There is evidence of dyslexia and low self esteem.

Mother

The majority of the information held on Mother relates to health issues. In her early years she was diagnosed with eating problems and asthma. She has very small eyes and was registered as partially sighted in 1997.

In 2004 she was prescribed the contraceptive pill due to period problems. Also in 2004 she was referred to CAMHS for her eating disorder but did not attend the appointment.

In April 2009 Mother was admitted to hospital with abdominal pains, she had a kidney infection and a cyst. At this time the child's father was identified as her boyfriend.

Mother presents as having a learning difficulty, she is a vulnerable person who could be mistaken for being younger than her years.

There is no information available regarding Mother's schooling or her abilities. Her parents have been supportive of her, including in recent times. There was no involvement from Social Care during Mother's childhood.

Parental relationship

In April 2009, it is understood that parents were in a relationship, Father would have been almost 29 years of age and Mother was 17 years of age. At this time, Father was not engaged with services and was not working. From the history, it would appear he was still using drugs.

In January 2010, Mother was assaulted by Father. He dragged her to the ground by her hair and punched her in the face. He received a caution for this offence. There is no record of medical attention being sought in relation to this incident.

In May 2010, there was a dispute in the street between the couple following Father being dissatisfied by the response from housing. No violence was recorded on this occasion.

In August 2010, Father's ex partner's new boyfriend reported concerns about contact to his son. Father had apparently placed comments of a highly concerning nature on Facebook, threatening violence and arson. The Police saw Mother in relation to these comments and she expressed no concern, saying that they were lyrics from a song. This issue was not followed up and represents a missed opportunity.

In June 2010, Mother's pregnancy was confirmed. She attended her first appointment with the midwife on 08.07.10. Father attended this appointment with her as he did all appointments throughout her pregnancy. The midwife was told that the pregnancy was planned.

During her pregnancy, Mother presented to the hospital on eight occasions, these were not considered to be significant and the number of presentations or the reasons for them was not seen as a concern. During her pregnancy, Mother had several midwives and it is unclear whether information was shared appropriately.

In November 2010 the midwife made a referral to Children's Social Care, the referral was sent six days later due to problems with the fax machine.

The midwife was concerned about domestic violence and the risk to the unborn child. A discussion took place with a duty worker but despite the fact that there was information on Social Care records about previous domestic violence with other partners; the record was not checked by the duty worker. Consideration was given to the completion of a CAF but this was not actioned by the midwife. This represents a missed opportunity by the midwife making an assumption that no historical concerns existed.

The midwife however, ensured that an alert was placed on Mother's record at the Nottinghamshire Hospital stating that there may be an issue of domestic violence and if concerns came to light, a referral should be made to Children's Social Care.

The alert was clearly placed but no further concerns were apparent, either during pregnancy or labour.

The midwife discussed safe sleeping with parents and both denied drinking alcohol or smoking. The issue of domestic violence was also discussed with Mother, she denied this but described Father as domineering.

The Child

There were no complications following the birth, Father was present and Mother and baby were discharged after six hours.

The midwife made her first post natal visit but could not gain access as Mother was out with the baby visiting family. A further visit was made and once again parents denied smoking, drinking or drug taking. No concerns were expressed about Mother's care of the child.

The case was handed over to the health visitor, who visited and no concerns were expressed during this visit; a thorough examination revealed that the child was doing well.

Later the same month, Mother became ill and was admitted to hospital where she remained for several weeks. No professional assessment was made about the care of the child, Father was clear that he would care for the baby with the help and support of maternal grandparents. There were no checks made about the arrangements.

Mother was tearful and anxious that she had not seen her baby. It is unclear what arrangements were made for visits but it must also be recognised that initially Mother was seriously ill and would have been unable to respond during visits.

Health Visitor telephoned and Father informed her that Mother was in hospital and that the child was with maternal grandmother. The Health Visitor tried several times, without success, to gain information about the situation from the Nottinghamshire Hospital.

Maternal grandmother returned the baby to Father as she became ill. Father told Mother that he could not care for the child but he was told by Mother that he must take responsibility for the baby. Maternal grandmother enquired daily whether Father was coping and was told that he was.

At 04:36 on the day the child died, a 999 call was made for an ambulance to attend the child. The ambulance arrived in three minutes. Father was not seen to be carrying out CPR and it was noted that there was blood on the quilt cover and the child's face. There was a strong smell of cannabis and a large dog was present.

The child was taken to hospital and tragically died the same day.

Initially, the death appeared to be caused by overlaying, Father changed his story to say that the dog had caused the child's death but then said he had overlaid the child. There are to be no further Police enquires into the child's death.

Father admitted that he had used both cannabis and alcohol during the period prior to the child's death.

Conclusions

This case highlights the need for effective communication both between agencies and by professionals within agencies. There was significant information held by agencies which evidenced that Father was a dangerous man who was unstable and unpredictable. Although there is no evidence that Father has directly harmed children, his offending history, particularly in relation to domestic violence, would strongly suggest that he should not have care of children without strong safeguarding measures in place. In the light of the child's death it could be argued that, whilst he could not be held directly responsible, he should not be in any household where children are present.

Should information come to light about him either fathering a child, or moving into a household with children, safeguarding procedures should immediately be initiated. The combination of Father's dangerousness and Mother's vulnerability should have resulted in an assessment being undertaken, at least at the level of a CAF.

The review has highlighted a number of missed opportunities to act sooner which could have potentially prevented the child's death.

These include the following:

Failure of the Substance Misuse Voluntary Agency to report concerns:

The information that Father had threatened his mother with a gun should have been immediately referred to the Police and to Children's Social Care. A criminal offence was likely and at that time Father was living with a partner who had children.
It is clear that procedures were not followed in relation to this issue.

b) Failure of agencies to attend MAPPA meetings and understand MAPPA processes

Key agencies did not attend MAPPA Level 2 meetings and did not fully understand that when the level of management is reduced that this does not necessarily equate to reduced risk.

c) Information on Facebook

Given Father's history of domestic violence and arson offences, the information posted on Facebook should have assumed a higher importance, particularly when Mother became pregnant.

d) Assessments

There were a number of opportunities to undertake assessments in this case. Some of these are already stated above.

The referral to Social Care in December 2010 represents a missed opportunity to undertake a CAF or an Initial Assessment, especially as the information relating to Father was available on the Social Care information system.

The numerous presentations to hospital during pregnancy should have triggered concerns that Mother may have been seeking help, again in the light of Father's history.

The arrangements for the child's care when Mother became ill should have been considered again in view of Father's history.

Recommendations

LSCB

- Ensure that the Multi-Agency Escalation Policy is embedded into the practice of all agencies and that the Policy is available on the LSCB website.
- In conjunction with MAPPA arrangements, ensure that staff in relevant agencies are clear about the management of offenders under MAPPA processes and that levels of management and levels of risk are not always the same.
- Ensure attendance of key staff at MAPPA meetings.
- The LSCB should make representation to the Department of Health, highlighting the need for single health records in relation to children where there are safeguarding concerns in order to ensure effective information sharing between health professionals.

Health Agencies

- Seek to establish a system whereby health records can be made more accessible to key professionals. This should include any safeguarding concerns which need to be restricted so that parents are not alerted to sharing of sensitive information.
- Processes whereby midwives undertake CAF/pre-CAF assessments to be established urgently and a plan of action presented to the LSCB.
- Labour suites to be alert to women who present on multiple occasions as this behaviour may be linked to domestic violence. Community midwives should be alerted in these situations.
- Where mothers of very young babies are admitted to hospital, specific enquiries should be made about the childcare arrangements and any concerns referred to relevant agencies.
- Examine the transfer of cases from midwifery to health visiting to ensure that essential information is not lost.

Children's Social Care

- All assessments should include historical information in relation to parents, including information of previous relationships. (Particular attention should be given to domestic violence, substance misuse, offending behaviour and mental health issues).
- Social Care to examine opportunities for agencies to access advice with regard to safeguarding issues.
- All staff receiving referrals where there is safeguarding or welfare concerns for children should complete a full record check before deciding on action required.

Substance Misuse Voluntary Agency

The Substance Misuse Voluntary Agency should review systems for ensuring that all safeguarding concerns which emerge from work with adults are referred to the relevant agencies. It should provide a report to the LSCB outlining processes and methods of audit and quality assurance.