Gloucestershire Safeguarding Children Board

Serious Case Reviews

Executive Summary

0205

Aged 10 months

Overview Author
Richard Townsend
Independent Consultant
July 06

Paper 76a/2006

CYPSP
Gloucestershire's Children and Young People's
Strategic Partnership

Introduction

Elisabeth was a seriously disabled child who died aged fourteen months. At the time of her death her name was on the child protection register in Gloucestershire because of concerns around neglect – caused primarily to her mother's substance misuse. Although it has never been established that Elisabeth's death was anything other than natural causes, there was concern that her quality of life was less than it might have been because of issues around her care. The Serious Case Review was held because of the child protection concerns relating to Elisabeth and her brother, Mark. Elisabeth was the second child of her parents; her brother was aged 9 years when she died. The two children lived at home with their parents.

Elisabeth's mother, Karen, was a known heroin user and was receiving support from the mental health addiction treatment service. Very little was known about Elisabeth's father or the role he played within the family. The family received significant support from the children's paternal grandparents. In the months leading up to her death her brother Mark became ill and was eventually diagnosed with leukaemia.

In the first month of her life Elisabeth was diagnosed as suffering from a life threatening condition, Cerebral Palsy and visual defects. She was severely disabled exhibiting serious feeding difficulties from birth and was admitted to the special Care Baby Unit. She developed neonatal seizures as well as opiate withdrawal symptoms. Naso-gastric feeding was started as oral feeding was regarded as unsafe. Elisabeth was discharged home at six weeks of age and after her parents had received training on how to pass the naso-gastric tube, oral stimulation exercises and resuscitation. There were two other hospital admissions before Elisabeth returned home five months before her death.

The children and the family received a high level of support from the health services in respect of both children, the education service in respect of Mark and the mental health service in respect of the children's mother. Concerns were expressed about the parents life style, which were to some extent considered cultural, the parents' held Pagan beliefs. The concerns related to poor home conditions, a very dark, gloomy household, poor school attendance, poor records of medical attendance and an unwillingness or inability to act on the advice of professionals. Of particular concern was an apparent reluctance to seek medical advice about Mark and to ignore advice or to change the treatment of Elisabeth without the approval of the medical services.

Concerns increased significantly six months before Elisabeth died and a child protection conference was held three months later.

This review has revealed that the working relationship between the professionals and the family and how the professionals worked together were significant. The family presented as welcoming and, superficially at least, had a good relationship with all the professionals. However, it is clear that from the time when Mark entered education that the parents displayed cultural patterns that made it difficult for them to conform and to which the professionals were unsure how to respond. The extent to which the parents' lifestyle influenced how the professionals related to them is unclear but possibly too much allowance was made for their behaviour being related to their religious beliefs. There is concern that the parents were not challenged sufficiently over issues of concern and that plans made were not rigorously enforced or responded to if they were not achieved.

The review demonstrates very high levels of contact between individual professionals and groups of professionals. Many formal meetings are recorded in the chronology and included planning meetings, professionals meetings, hospital meetings and a Child Protection (and review) Conference was held. Over all a great deal of effort was spent in getting these parents to appropriately meet the needs of the children. Concern has been raised that there was a lack of co-ordination and or leadership and a lack of evaluation about progress of plans. This issue was complicated by the fact that the family had two GPs from two practices and there was difficulties sharing of information between the two practices. The review concluded that the approach of professionals to the family was not meeting the needs of the children, as change was not affected.

The above comments need to be put into perspective. In many ways communication was quite good, meetings were held at times of crisis and review meetings were held on time. In addition there is little evidence making a link between Elisabeth's death and the behaviour or actions of her parents and specifically it is clear that the failure to implement feeding and treatment programmes effectively did not directly impact on Elisabeth's death. What is clear is that both Elisabeth and Mark would have had more comfortable and satisfactory lives had the parents accepted and implemented the advice they were given and the children would not have suffered neglect.

Summary of Concerns and Recommendations

Failure to Initiate a Strategy Discussion at the Appropriate Time

In the months prior to Elisabeth's death there was clear evidence of deterioration in the circumstances of Elisabeth and Mark. High levels of concern were already felt for these children as is evidenced by the high levels of professional activity and numerous interagency meetings prior to this point. Although a professional meeting was held during this time there is no record of an action plan emerging

from the meeting that would have addressed the children's needs, or of any discussion in which the possibility of holding a Strategy Discussion was raised. It is a conclusion of the review that a Strategy Discussion should have been called, this would on the evidence almost certainly have led to an enquiry under section 47 of the Children Act and an earlier Child Protection Conference.

Recommendation 1
That clear protocols should be developed and agreed by ACPC detailing the thresholds that once met would automatically trigger a Strategy Discussion to decide whether a case should be managed under sect.17 of the Children Act or sect 47.

Recommendation 2.
All discussions in relation to the type of meeting to be held where there is concern for the welfare of a child should be recorded by the Social Worker on the child's file specifying why that particular level of meeting was appropriate given the levels of concern that had been identified.

Failure of professionals to communicate appropriately at all times

This is not a case where significant failure in communication led to children being harmed. It is clear that all those involved worked hard to keep in touch however the review highlighted some significant areas for improvement. In particular there was a need for greater collection and analysis of patterns of missed appointments and incidents of failure of the parents to comply with plans or act on advice. There was confusion as to who had responsibility for co-ordinating services to the family. It was felt that the children would have benefited from the appointment of a lead professional who had an overview of the experience of the children and who was responsible for co-ordinating the work of professionals. This issue was resolved once the children's names were included on the Gloucestershire Child Protection Register with the appointment of a Keyworker.

The review highlighted a concern that the adult services in respect of Karen were not fully integrated into the planning for services for the children.

The need for a working chronology was also highlighted, particularly for the health services, to assist in the collection of information about the responses of the parents.

Recommendation 3
Health should appoint an Agency lead professional to co-ordinate the activities of Health professionals in complex cases

Recommendation 4
Guidance should be developed in relation to the criteria for the appointment of a lead professional in all complex child care cases following a Children in Need meeting or Review meeting where there are significant concerns but where a section 47 enquiry is not thought appropriate

Recommendation 5
Consideration should always be given to inviting key professionals working with the adults in the family to Child Protection Conferences, to Children in Need Reviews and Serious Case Reviews. Agencies should amend their procedures to reflect this.

Recommendation 6
Consideration should be given as to how the outcomes of Serious Case Reviews are disseminated to front line staff and included in future training programmes.

Families Split Between GP Practices

This family was split for medical care between two GP practices, the children Elisabeth and Mark each attending a different practice, as did the parents. There were no formal arrangements in place for the exchange of information between practices, although this undoubtedly happened informally. It is also clear that within the two practices each GP fulfilled a different role in relation to the children. Dr N having very little contact with Elisabeth while Dr. E was very actively involved in the care of Mark. The variation in the extent to which the GP were involved with the children is mostly due to the fact that essentially all of Elisabeth's medical needs were met through hospital based services.

Potentially children whose names are on the Child Protection Register could be at risk because of the possibility of communication breakdown if children in the same family have their medical needs met by different GP practices. In addition GP could become "detached " from cases where the child needs are met by other Health Professionals and thereby risk not have an overview of the family.

Recommendation 7.
All General Practitioners should encourage families to register with the same practice. When a child in the family is on the Child Protection Register this should be a requirement of the child protection plan. Where the parents do not agree to attendance at a single practice then the practices involved must put in place formal arrangements for the exchange of information.

Recommendation 8
GP should be recommended, as a matter of good practice, to undertake a joint consultation, with the Health Visitor or School Nurse for all children on the Child Protection Register who are not routinely seen by the GP along with their parents.

Failure to maintain focus and drive through care plans

The review concluded that there was, at key points in time, a failure to ensure that the parents acted upon key elements of care plans. A number of possible explanations have been advanced as to why this happened and include, possible conflict in the minds of professionals as to how to accommodate the parents' lifestyle and the need to maintain good working relationships with them in order to keep contact rather while at the same time needing to challenge their negative behaviour.

The relationship between professional workers and parents is critical but comes secondary to the need to protect the child and keeping the child and its needs as the focus of our concerns. This is not to suggest that the children's needs were not seen as paramount by the workers in this situation but what is demonstrated is that a good relationship with the adults is pointless if it fails to deliver positive changes for the children.

Recommendation 9
The GSCP should review its existing training programmes to ensure that they adequately address issues in relation to achieving the balance between working positively with parents while at the same time ensuring the protection of the child and delivering child protection plans remains the focus of intervention.

Duncan Siret
Safeguarding Children Manager
20th June 06