Gloucestershire Safeguarding Children Board

Serious Case Reviews

# Executive Summary

# 0607

## Aged 9 months

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## 1. Introduction

**1.1** Please note that names used in this executive summary have been changed to preserve anonymity.

**1.2** Conor, aged 9 months old, was admitted to hospital in July 2007 suffering from head injuries. He died the following day of a fracture to the rear of his skull. The injuries were believed to be non-accidental. Gloucestershire Safeguarding Children Board (GSCB) initiated a Serious Case Review in August 2007 in line with the guidance provided in 'Working Together to Safeguard Children: a guide to interagency working to safeguard and promote the welfare of children' revised in 2006. This document can be found in the 'Every Child Matters' website www.everychildmatters.gov.uk.

**1.3** This review has concluded that there are areas of policy and practice that need strengthening, however the review has not demonstrated that any weakness in policy and practice contributed in anyway to the death of this child.

**1.4** A genogram is included in appendix one.

## 2. Serious Case Review Process

**2.1** Serious Case Reviews are undertaken as standard practice whenever an incident of serious harm to children occurs and where there may be public interest.

**2.2** Serious Case Reviews require each agency that had some direct involvement with identified child/children and their carers to undertake an Individual Management Review (IMR). This review must look openly and critically at individual and organisational practice in this case. Each agency is required to produce a chronology of its contact with the children and their carers. Managers conducting the Individual Management Reviews (IMRs) must not be directly concerned with the services provided for the children or carers, or the immediate line manager of the practitioners involved.

**2.3** Members of a Serious Case Review Sub Committee bring together the information provided from the Individual Management Reviews and then consider the professional practice and inter agency working as it relates to the subjects of the review. Members of this Serious Case Review Sub-Committee in Gloucestershire are senior experienced professionals from Gloucestershire Children and Young Person's Directorate (CYPD) (covering social care and education services), Gloucestershire Hospital Trust, Gloucestershire PCT, Gloucestershire NHS Partnership Trust, the Probation Service, Gloucestershire Constabulary, Multi Agency Public Protection Arrangements and Voluntary Community Services.

**2.4** The Serious Case Review Sub-Committee must then commission an independent person, as laid down in 'Working Together' to bring together the Individual Management Reviews and produce an Overview Report.

## 3. Case Details

**3.1** The scope of this review was to cover the period from when Conor's mother Bridget was pregnant with her first child Alana in 1999 up to Conor's death in July 2007

**3.2** Conor, together with his older brother Ben and sister Alana lived with their parents Francis and Bridget as part of the traveler community. The family lived mainly in the Hertfordshire area when Alana was born in 2000 and Ben in 2002. The children suffered from respiratory infections and scabies but were otherwise well. The family moved to a house in Gloucester shortly after Conor's birth in 2006 and continued to travel frequently to other areas of the country.

**3.4** Bridget received hospital treatment in Kettering for facial and head injuries in February 2004 and in January 2006. In both cases she alleged at the time that Francis had hit her around the head and face. The police were not informed of the assault in 2004 but were involved following the assault in 2006. Francis was charged with the offence of common assault by battery. In Bridget's statement to the police she maintains that Alana and Ben witnessed the assault. No referral was made to social care by the police as Bridget did not give any forwarding address. Bridget withdrew her complaint in May 2006, stating that she had been drunk at the time of the assault and that she had been told it was not Francis who had assaulted her.

**3.5** The family were living in Gloucester in September 2006. Alana and Ben started schools in Gloucester having previously been at school in Somerset. The Gloucester schools were given inaccurate dates of birth for both children and so believed them to be a year older than they were and where placed in a year group older than their chronological age, this may have hindered their progress in school. Both children were offered additional support by the Traveller Education Service but poor school attendance may also have hindered their progress.

**3.6** Conor was born in Gloucester in October 2006. The GP was phoned from the hospital on 1st November and advised that Conor and his mother had been discharged from hospital. At the time of the SCR the midwifery post natal care plan could not be located although the midwife does remember visiting the family home. The health visitor was told about Conor by another family living nearby when she was visiting them and made contact immediately. The health visitor undertook four home visits in the month following Conor's birth.

**3.7** In the period between November 2006 and January 2007, Bridget took Conor to Gloucester Royal Hospital Emergency Department on three occasions with

different concerns. She was given an appointment with the paediatric surgeon in January, which was not kept. Later that month, Conor was admitted to hospital in Coventry with breathing problems. Bridget told hospital staff that she had left Francis because of domestic abuse. She was provided with bed and breakfast accommodation and stated she wanted to go to a refuge. She did not want a referral to social care. She was referred to a local health visitor who requested the records be sent from Gloucester to Coventry.

**3.8** Meanwhile Bridget had returned to Gloucester with the children. In early March 2007 the police were called to an incident in Gloucester. Bridget alleged that Francis had assaulted her. She had minor injuries, which did not require hospital treatment. Both Bridget and Francis were drunk at the time of the incident. The children were present when the police arrived although it is not clear whether they witnessed the assault. Francis was arrested. Whilst taking her statement, the police became aware that Bridget could not read or write. In her statement Bridget told the police that Francis had hit her before and that he becomes violent when drunk. The police attending the incident did not complete a Domestic Violence Risk Assessment Form so the incident was not subject to any form of formal risk assessment by the appropriate Police Domestic Violence Abuse Unit.

**3.9** The police followed up the incident with a letter to Bridget with details of the Independent Domestic Violence Advise Line. They also logged a child welfare concern with the Safeguarding Children Service and sent the same information to the Social Care Access Service. The child welfare concern provided information about the incident but stated that there had been no previous incidents. This was contrary to the information from Bridget and from police databases about previous incidents.

**3.10** The day after this incident, Bridget was back in Coventry and received a visit from the Coventry Health Visitor. This health visitor was aware of the domestic abuse reported in January but it is not clear if she knew about the incident the day before in Gloucester.

**3.11** Bridget returned to Gloucester with the children later in March. There was liaison between the health visitors in Coventry and Gloucester. The Gloucester Health Visitor visited Bridget and saw Conor. Records show that the Health Visitor talked to Bridget about domestic abuse and discussed the involvement of social care. Bridget did not want social care involvement. At this point, no information had been passed to the Gloucester Health Visitor about the recent domestic abuse incident. It is assumed that Bridget was living with Francis at this point.

**3.12** The Gloucester Health Visitor followed up this visit with phone calls to remind Bridget of appointments. This facilitated immunizations for all three children and hospital appointments for Conor.

**3.13** In early April, Bridget provided a statement withdrawing her support for any prosecution of Francis for the assault in March. She says that she was drunk at the time and cannot recall any details of the incident. The police advice file to the Crown Prosecution Service does not include information about previous assaults.

**3.14** Meanwhile, the Gloucester Social Care Access Service Team Manager had allocated the case to a social worker who contacted the Gloucester Health Visitor in April. The plan was for the Health Visitor to talk to Bridget about the Social Worker and Health Visitor undertaking a joint visit to talk about the domestic abuse. When the Health Visitor made the visit in April, the family was not at home. The Social Worker was made aware of this failed appointment. Coventry health visitor records state that the family was based in that area during May and June.

**3.15** A separate concern that Alana and Ben had been left very early at their Gloucester school on their own one morning in June, was reported to the Social Care Access Service. This was followed up by the Gloucester Health Visitor who undertook a home visit the next day. The children were being looked after by their grandmother who explained that she had mistaken the time on the morning in question. All three children were seen by the Health Visitor and reported to be well. The Health Visitor took the opportunity to undertake Conor's next developmental review. There were no concerns about Conor's health or development. This home visit was ten days before Conor died.

**3.16** The Health Visitor contacted the Social Worker and confirmed that the children appeared well and the grandmother was protective. After consultation with the Team Manager, the decision was taken to close the case. This was on the understanding that there had been only one referral of domestic abuse, no previous involvement with the family and other professionals were not expressing any concerns. The Health Visitor planned to invite Bridget to the clinic to discuss the domestic abuse referral.

**3.17** The family were living in Padstow later in June and Bridget enrolled Alana and Ben at school there. On the 1st July Conor was admitted to hospital in Cornwall with a serious head injury. The following day he was diagnosed as brain stem dead and his life support machine switched off. The conclusion of the post mortem is that the injuries sustained are consistent with him having been shaken or thrown across the room. A fracture to the rear of the skull was identified.

## 4. Key Findings and Summary

**4.1** There is evidence of a pattern of domestic abuse perpetrated against Bridget by her husband Francis. He also has a history of violent behaviour when drunk. It is likely that all the children have witnessed this abusive behaviour and risked being hurt emotionally and physically to some extent. However, there was no evidence prior to the death of Conor that the children had been physically harmed.

**4.2** Although Francis was charged with offences against Bridget on two occasions, she withdrew her complaint on both occasions using her own drunkenness as a reason for taking some of the blame. The police failed to give accurate information about previous incidents to the Crown Prosecution Service when they reviewed the file on the most recent charge. As a result, there was no opportunity through the court to ensure that Francis understood that his behaviour was unacceptable or to challenge the beliefs that underlie domestic abuse.

**4.3** Bridget did leave Francis for her own safety on more than one occasion and told police and health professionals that she was being abused. However, each request for help was dealt with in isolation. Bridget and the children moved immediately after domestic abuse incidents on at least two occasions and the whole family moved frequently. This made it difficult for agencies to access records and to follow up work with the family. Although health visitors were aware that there was domestic abuse and discussed this with Bridget it is not clear whether she understood the potential risks to the welfare of the children. There is no record that her use of alcohol was explored. Francis was not involved in any discussion

**4.4** Professionals working with the family were aware of the traveller culture and there is evidence of good practice in meeting their needs particularly by health visitors. The children's health problems and Bridget's inability to read and write reflect social inequalities faced by gypsy and traveller communities. Bridget's literacy problems probably contributed to her lack of knowledge about the children's dates of birth and difficulty in keeping appointments. It is noticeable that she responded positively to health visitors who kept in touch by phone and facilitated appointments with hospital consultants. The lack of accurate dates of birth for the older children led to flawed assessments of the older children's educational needs. Schools did not use systems in place to track information and tolerated poor attendance. Although the Traveller Education Service was used to support Alana and Ben, it did not have the desired impact. Clearer practice guidance on working with gypsy and traveller families would have helped all agencies.

**4.5** The fact that the family moved around the country made information sharing difficult. Because traveller families are less likely to build up a relationship with

health and education professionals, strict adherence to agency recording and child protection procedures is particularly relevant. There were lapses in recording and procedures highlighted in police, health and education Individual Management Reviews.

**4.6** The volume of child welfare concerns from the Police Domestic Abuse Unit and the processing by both the Gloucestershire Safeguarding Children Service and Children and Young People's Directorate (CYPD) Customer Service Help Desk could be masking the true nature and extent of child protection issues. It could also be impacting on the process of prioritising resources. Concerns were also raised about the accuracy and completeness of information sent in child welfare concerns from the Police Domestic Abuse Unit compared to that received from the Police Child Protection Unit.

**4.7** The opportunity to bring together all the known information about the domestic abuse was missed in March 2007 after the incident reported to the police. Although the Police Domestic Abuse Unit initiated a child welfare concern, inaccurate information was given i.e. there was no history of abuse. The social care Access Service did allocate the case to a Social Worker who planned a joint visit with the Health Visitor. The Social Worker and Health visitor did talk to each other and the children were all seen by the Health Visitor. However, both professionals did not have all the available information and did not involve education services. The joint visit plan was subsequently abandoned on the understanding that professionals involved with the family had no concerns and that there were no previous referrals relating to domestic abuse. If all the information about previous abuse had been available, it is possible that a strategy discussion would have been called involving all professionals working with the family. Because there was no evidence that the children had been harmed, it is unlikely that this would have prompted a child protection inquiry under S47 Children Act 1989. However, a more accurate assessment of the risks posed to the children would have been completed which would have informed agencies such as schools and health with regard to meeting the children's needs. It cannot however be concluded that such action would have prevented Conor's death.

## 5. Recommendations

1. The process for logging a child welfare concern by the Police Domestic Abuse Unit should be improved to ensure that: (i) full and accurate information is provided (ii) child protection concerns are identified. Only cases with identified child protection concerns should be logged. The need for two parallel processes should be included in the review.

2. When a referral involving a child or children of school age is accepted by the Access Service, education records should automatically be accessed and the relevant school(s) included in the assessment process**.** If social

care professionals believe that a family has moved out of county, the Education Management System (EMS) should be accessed prior to closing a case to confirm the school's understanding of whether they have moved.

3. Schools should be reminded that there is a facility to check with the appropriate PCT Health Trust if there is any concern regarding a child's date of birth.

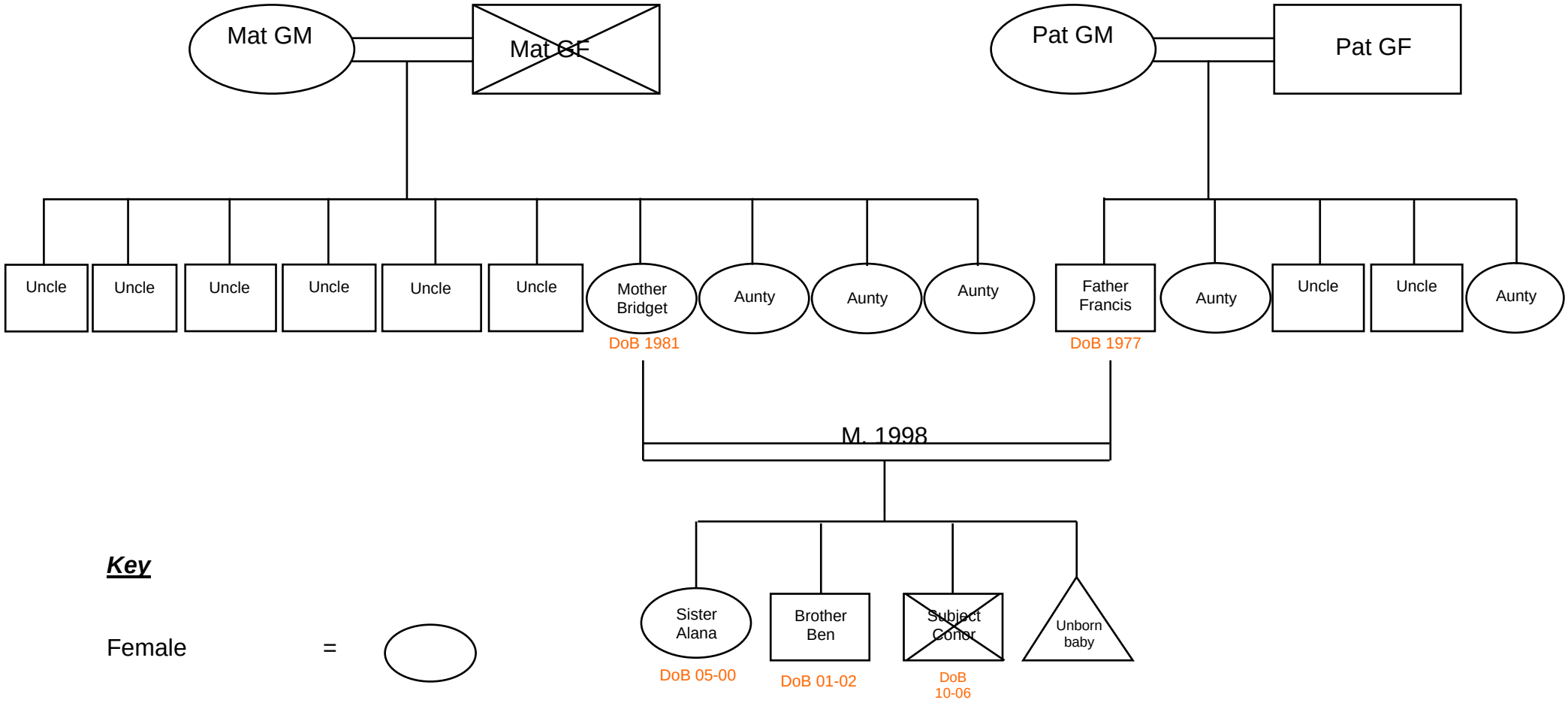
4. Good practice guidance in working with Gypsy and Traveller families relevant to all agencies needs to be produced in consultation with representatives from these communities in Gloucestershire. This could draw on lessons from previous Serious Case Reviews involving hard to reach families as well as issues such as adult literacy and translation. This work would be consistent with the recommendations of the Gloucestershire County Council Gypsy and Traveller Accommodation Assessment completed in October 2007.

5. The role and presence of fathers as well as other significant adults needs to be included in assessments. This point has been raised in other Serious Case Reviews. Barriers to including fathers and other adults could be practical, for instance working hours or lack of skills and experience in working with men. These barriers need to be identified and addressed in procedures and good practice guidance.

6. The difficulties in recording and sharing information on Gypsy and Traveller families should be raised nationally.

Julia Oulton
19th February 2008

# Appendix One - 0607 Genogram




***Key***

Female =

Male =

Male deceased =

Unborn =