Executive Summary

Serious Case Review

Child S

Completed by the WSSCP: 29 November 2017

1 A Serious Case Review (SCR) was completed in 2017 in respect of a seven-month-old child to be referred to in this report as Child S. They suffered life-changing injuries while in the care of their parents in 2016. Toxicology reports found traces of cocaine and amphetamine in the child's system. Both parents were convicted of 'neglect of a child to cause unnecessary suffering or injury' in 2023.

2 The criminal investigation delayed publication of the review report, but learning briefings were compiled and circulated in 2018 and 2020. The West Sussex Safeguarding Children Partnership's (WSSCP) multi-agency action plan has been completed.

3 Prior to the life-threatening event, professionals believed Child S was well cared for by their mother. However, learning has been identified for the agencies involved and for the West Sussex Safeguarding Children Board (now WSSCP), which is summarised below.

Case details

4 The child's mother had a conviction and nine-year prison sentence in a South American country for drug smuggling, and due to this her older children were not living in her care. They lived in another part of England as had Mother until around two years before Child S was born. Father was local to West Sussex. He was known to the police and his General Practitioner (GP) historically for issues with drugs and alcohol, and one non-recent domestic abuse incident with a previous partner.

5 The perception of professionals involved with Mother in respect of her pregnancy was that she was open with professionals about her custodial sentence, her two older children, her depression, and domestic abuse with a previous partner. She stated she had never been a drug user but that she had been exploited, leading to her conviction for drug trafficking.

6 There is no evidence in any agency records that Mother had sought or received services due to any drug use in West Sussex. However, as part of this review the GP report author found two references to Mother telling her GP in 2003 that she had been using amphetamines. This was not included in the summary of Mother's GP records that transferred to her GP in West Sussex. The explanation given was that case summaries have become a considerable administration task and that some information can be missed.

7 Mother had been on anti-depressant medication when she became pregnant and was referred to the Specialist Perinatal Mental Health Service by her GP. She did not engage. Mother had stopped taking her medication while pregnant and the GP and midwives did not follow up with her about her lack of attendance.

8 Following Mother's maternity booking appointment, the midwife wrote a handwritten referral to Children's Social Care (CSC) Access Point (CAP[1]). The issues highlighted were the

[1] This was prior to the implementation of the MASH in West Sussex.

historic prison sentence, Mother's stated financial and housing issues, and the disclosure of domestic violence with a previous partner. There is no record that this hand-written and posted referral was received by the CAP and the midwifery service did not enquire or follow up the outcome of the referral. The GP and the Health Visitor that later took on responsibility for the child were not copied into the referral as this was not the practice at the time. It was only when the child was born that the hospital noted the information and contacted the newly formed West Sussex Multi Agency Safeguarding Hub (MASH).

9 The midwifery team requested and received midwifery information from the area where Mother had lived when her older children were born. There was no information shared of concern. Mother declined an antenatal appointment with the health visitor that had been offered. This was not pursued by the health visitor as it is not unusual for parents to not engage when they have had previous children, and because the health visitor was not aware of the midwife's referral to CSC until after the birth of Child S.

10 The child's father did not attend any appointments with the community midwife. This was also not unusual. Mother was asked about domestic abuse, and she said it was not an issue in this relationship.

11 Having been alerted to the information about Mother's past, it was agreed that a social work assessment was required 'to get a full chronology and history of family functioning and to create a safety plan that mitigates the risk and prepares for lapses, which would include the support and intervention of members of the wider family. It was recorded that consideration should also be given to having a Strategy Meeting.[2] This initial assessment and decision was then passed on to the manager of the local Assessment and Intervention service. The CSC team manager who then became responsible for the case decided that a duty social worker should attend the home and do a visit to see if an assessment was in fact required. (Called 'threshold visits' locally.[3])

12 The social worker met Mother, saw Child S and met members of Father's extended family and was reassured by both Mother and Child S's presentation and the support they were receiving. They did not think a further assessment was required. The team manager agreed. No further action was taken. The social worker was not aware of the recommendation made by the MASH manager that a full Child and Family Assessment should be completed, and that consideration could be given to a Strategy Meeting. The social worker did not record the visit, but the next day the team manager summarised the verbal report given by the social worker onto Child S's case record, cancelled the Child and Family assessment form and the case was closed.

13 After Child S and Mother were discharged from hospital, they received the standard level of visiting from community midwives. No concerns were noted regarding Mother's parenting and Child S was said to be thriving. Father was not seen. The health visitor showed curiosity about Mother's history, but it was agreed that a universal provision was required.

14 When they were seven months old Child S was taken to hospital by their parents with a BRUE (brief resolved unexpected event) and had to be resuscitated. Some discrepancies had been noted about timings, whether the parents lived together, and where exactly they lived. Concerns were recorded at the hospital over the coming week about Father being

[2] Strategy meeting - to plan a child protection investigation and consider the need to protect a child who may have suffered or be at risk of suffering significant harm under S47 Children Act 1989.

[3] A thorough management review has verified that these types of visits no longer take place, and clear directives have been implemented across the service that Group Manager authorisation must be given for any changes to referral outcomes.

drunk. There were no answers to how the child received their brain injury until the toxicology results were received until almost 4 weeks after testing and there was evidence of cocaine in a blood sample. This led to a strategy meeting being held the next day. A subsequent hair-strand test also found the presence of alcohol and amphetamines in the child's system.

Learning points:

- Practice that is entirely mother-focused does not give a full understanding of the risk or protective factors within a family for a child.
- If co-sleeping is identified as an issue, the attitudes of both parents should be established and considered.
- When there are no current and obvious concerns about a child, professionals outside of Children's Social Care do not always undertake checks with other agencies.
- There are often barriers to information sharing. When considering why GPs are not always contacted, professionals stated that: 'They probably don't know the child. They won't share anything if the matter is not a S47. And it is hard to speak to a GP in person.' It is therefore important to understand these barriers, to pursue information despite them, to challenge if information is not shared, and to address the issues identified.
- Professionals need to be clear about what information should and can be shared. When speaking to each other, professionals need to state that they are requesting information as they may be worried and need to be fully informed before deciding if a referral to the MASH is appropriate.
- Although it is very rare for a referral to be 'lost', it is the responsibility of all those who make referrals to ask what happened next if the information has not been shared.
- Professionals need the appropriate tools, such as access to a computer, to undertake their work to the standard that is required.
- Professionals can have a perception of drug users and what they look and act like. In this case, information now available from the subsequent care proceedings show that both parents had been misusing drugs throughout the time being considered, despite not presenting as drug users.
- Professionals need to be curious, not accept things at face value, and check with other professionals (including in other geographical areas) what a parent is saying if their history may indicate potential safeguarding concerns.
- Professionals report that the perceived experience, expertise, or status of other professionals can have an impact on how confident they feel in challenging or escalating differences of opinion.
- Most BRUEs have a medical or physiological basis, although a precise explanation is not always found. Some have unnatural causes and assessment should always include consideration of these through careful history taking, examination and investigation, like those undertaken for unexplained child deaths. This should include being aware that parents/carers can give illegal drugs and alcohol to children, and children can ingest drugs/alcohol accidentally.
- Clinicians must consider all possible causes of BRUEs (or collapse/neurological compromise) including abuse, neglect and accidental or non-accidental ingestion of illicit drugs/substances, as part of the differential diagnosis.

- It is important that professionals establish what 'likely,' 'possibly,' probably,' and other such statements actually mean, for example in the context of describing neglect or a non-accidental injury, so that an informed judgment can be made about the need for the involvement of safeguarding professionals.
- Health professionals need to be more explicit when speaking to the MASH if abuse or neglect is part of a differential diagnosis for a child.
- When a very ill child is referred to the MASH, and non-accidental injury remains a part of a differential diagnosis, the lead clinician with responsibility for the child and the MASH should speak within 24 hours so that a decision can be made regarding on-going involvement of the MASH.

Good Practice

It is important to also learn from the good practice identified during the course of a review. Several agencies demonstrated they are getting the basics right, including the following examples:

- The community and hospital Midwifery services noting that Mother's history required a referral, on two occasions.
- The communication between the hospital midwives and CSC following Child S's birth.
- The flexibility shown at the hospital to enable Child S and Mother to remain in hospital while the referral was considered by the MASH.
- Good consideration by the MASH to the referral after Child S's birth.
- Child S was seen by a social worker in a timely way following their birth.
- The hospital named nurse for safeguarding children escalated a disagreement when the information sought was not provided by the MASH prior to her referral about Child S.
- The involvement of the safeguarding teams at both hospitals following the BRUE.
- The toxicology sample was taken on the first day of the admission; this ensured any drugs were still in the child's system.
- The positive child protection response to the situation when the evidence of cocaine in Child S's toxicology testing was shared.

Recommendations:

The review made recommendations in the following areas:

- The need for midwives to have mobile access to computers.
- Supporting professionals to confidently ask questions of others to clarify their own assessments. The aim is for professionals to be able to say 'I may be concerned about this child. What do you know, as it might make me more or less worried?'
- Revision of procedures to ensure clarity about the response to BRUEs.
- A need to focus on learning identified in local reviews regarding fathers/mother's partners.
- A response to raise awareness of the risk in giving drugs to children, and to challenge perceptions of drug users, using this case as an example.