BEXLEY SAFEGUARDING CHILDREN BOARD

THE OVERVIEW REPORT OF THE SERIOUS CASE REVIEW IN RESPECT OF CHILD B

November 2012

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1. INTRODUCTION

1.1 Child B, who was nearly four years old, died in January 2011. He had been taken to hospital and was pronounced dead on arrival there. A young man, Young Person F, who had been in a relationship with his mother, was subsequently convicted of his manslaughter.

1.2 The circumstances of Child B's death were considered by the Standing Serious Case Review Panel of the Bexley Safeguarding Children Board (BSCB), and subsequently by the independent Chair of that Board, Mr Brian Boxall. Mr Boxall judged that the circumstances of Child B's death were such that it was necessary to conduct a Serious Case Review (SCR), in line with statutory requirements, as set out in the government's guidance[1]. This is the Overview Report from that SCR.

2. FAMILY SITUATION

2.1 Child B lived with his mother and brother. He had substantial contact with his father, and his father's extended family.

3. DECISION TO CONDUCT THIS SERIOUS CASE REVIEW

3.1 Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Safeguarding Boards to undertake reviews of serious cases. The Regulation defines a serious case as one where

(a) abuse or neglect of a child is known or suspected; and

(b) either –

(i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

3.2 The Standing Serious Case Review Panel of the Bexley Safeguarding Children Board first considered the death of Child B on 2nd February 2011. There was a range of views as to whether it would be appropriate to initiate a Serious Case Review prior to the conclusion of post mortem examinations, which could take some months. The Panel asked Mr Boxall to consider and make a decision as to whether and when a SCR should be initiated. Mr Boxall, on 9th February 2011, decided that there should be an immediate SCR, taking account of the following key factors:

- When Child B was brought to hospital on the day of his death, he had numerous injuries, including a broken leg, bruising to his liver and a significant bleed on the brain.

- Four days previously he had been taken to another hospital with physical injuries.

[1] Working Together to Safeguard Children (2010) – referred to in this report as "Working Together"

- The explanations offered for the causes of those injuries were unclear and inconsistent, and included an account offered by Young Person F (YPF) of accidentally hitting Child B. Child B's mother had stated that YPF was looking after Child B on both days when he was injured and subsequently taken to hospital.

- In December 2010 Child B's school had noticed that he had facial bruising. It was not clear that these injuries had been followed up in line with agreed inter-agency child protection arrangements.

- Child B had special needs because he was diagnosed with Dravet's Syndrome, a severe myoclonic epilepsy. However, he had not previously been known to have injuries of this nature or extent as a result of epileptic seizures.

3.3 In line with statutory guidance, the relevant regulatory body, Ofsted, was notified of the decision to conduct the SCR on 10th February 2011. That guidance also indicates that the target timescale for completion of SCRs is within 6 months so that this Review was to be completed by 10th August 2011.

3.4 The BSCB approved the reports from this Review on 28th July 2011. This report is being published now, in November 2012, following the conclusion of criminal proceedings against YPF.

4. SERIOUS CASE REVIEW PROCESS

4.1 The purposes of SCRs are set out in "Working Together" (Para 8.5). They are 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.*

4.2 During February 2011 the BSCB Manager made arrangements to appoint the independent people who are required to contribute to the conduct of SCRs. Details are attached at Appendix B.

4.3 The BSCB constituted a SCR Panel (the Panel) to manage and oversee the conduct of the Review. That Panel met for the first time on 15th February 2011. The membership of the Panel is set out in the Terms of Reference attached at Appendix A.

4.4 On the basis of what was known at this stage, it was determined that the following agencies should contribute to the Review. Those agencies with substantial and recent contact, or particular statutory child protection responsibilities, were required to submit full Individual Management Reviews, whereas agencies with less or less recent involvement provided reports for background information.

AGENCY	NATURE OF CONTRIBUTION

South London NHS Trust	Individual Management Review (IMR)
School attended by Child B	IMR
Oxleas NHS Foundation Trust	IMR
Bexley Care Trust (now NHS SE London, Bexley Business Support Unit)	IMR
Metropolitan Police Service	IMR
Royal Borough of Greenwich, Children's Social Care (re Young Person F)	IMR
L.B. Bexley, Children's Social Care	IMR
Dartford & Gravesham NHS Trust	Background information report
School attended by Child C	Background information report
General Practitioners	Background information report
Bexley SEN Service	Background information report
London Ambulance Service	Background information report
L.B. Bexley, Housing Service	Background information report
Bexley Portage Service	Background information report
Hampshire County Council	Background information report
Army Welfare Service	Background information report

4.5 The Terms of Reference for the Review were finalised following the first Panel meeting and are attached at Appendix A of this report. The SCR Panel determined that agencies should provide detailed accounts and analysis of their contact with the family from the birth of Child B in March 2007 until Child B's death, supported by a brief account of any relevant key contacts, events or decisions outside that period.

4.6 Agencies were asked to address in their reports all the issues detailed in the government's guidance[2], namely:

- Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?
- Did your organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made, in the light of assessments?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making decisions about children's services. Was this information recorded?

[2] Working Together Paragraph 8.39

- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- Were more senior managers or other organisations and professionals involved at points where they should have been?
- Was the work in this case consistent with your organisation's and the London Child Protection Committee policy and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

4.7 Agencies were further asked to analyse seven issues identified at this stage as specific to this case, namely:

- Child B was seen at school with facial injuries in December 2010. Did the action taken by the agencies and professionals involved meet his assessed needs?
- Was Child B's presentation at an Accident & Emergency Department on 17th January 2011 managed appropriately by the professionals involved taking into account both his health needs around his disability and the need to ensure he was safeguarded?
- What was the impact of Child B's disability on how his family functioned? Were appropriate support services provided to Child B and his family?
- Did agencies appropriately balance their responsibilities to support the adults caring for Child B with the requirement to protect him and promote his best interests?
- Were there any issues of culture or ethnicity which affected the response of Child B's family to his disability?
- Was Child B able to express his wishes and feelings? How was communication with Child B managed by those working with him?
- Are there any similarities between the key issues in this case and those which have arisen in any previous reviews (including internal reviews and "near misses") to which the agencies in this case have contributed? If so, can the agencies demonstrate that they had learned lessons and taken action to address those issues?

5. PARALLEL PROCESSES

5.1 The death of Child B has also been considered by the Coroner – to establish cause of death, and by police – to follow up the criminal aspects of the case. The Metropolitan Police Service representative on the SCR Panel acted as the link between this Review and coronial and criminal investigations.

5.2 NHS agencies are required to carry out reviews of "Serious Incidents" (SIs). For the NHS agencies involved, that requirement was met by the conduct of this Review.

6. METHODOLOGY USED TO DRAW UP THIS REPORT

6.1 This Overview Report is based principally on the agency IMRs and background information submitted. The structure of the report has been discussed previously between the author and OFSTED. It consists of

- A factual context and chronology.
- Commentary on the family situation and their input to the SCR.
- Analysis of the part played by each agency, and of their IMR, summarising their response to the "standard" Working Together issues detailed above.
- Closer analysis of the specific issues identified in the Terms of Reference, detailed above.
- An account of other issues arising from an overview of the case.
- Conclusions and recommendations.

7. NARRATIVE CHRONOLOGY

7.1 Introduction

7.1.1 Each of the agencies submitted a detailed chronology, in tabular form, of their involvement with the family of Child B in the period under review. Those submissions have been co-ordinated into an integrated tabular chronology of all involvement during the period under review, which is some 120 pages in length.

7.1.2 This section of this report aims to summarise that chronology in an accessible way. It does not include every contact, or failed contact, and does not provide a detailed account of all the work carried out.

7.1.3 There is no evidence that the relationship between Ms D and YPF was known to any of the agencies contributing to this Review before the death of Child B.

7.2 Background history

7.2.1 Ms D became unwell while serving with the Armed Forces in Germany in 2003. In July 2005 the family are known to have moved to Aldershot and Child C was born later that year. Ms D was treated for some time by her GP and community services before leaving the Army.

7.3 March 2007 – February 2008

7.3.1 In March 2007 Child B was born. A Health Visitor carried out a new birth visit promptly and Ms D, although tired, reported that she was otherwise well. However, at a subsequent visit a week later, Ms D reported feeling low. The health visitor gave general support and advice and visited on a weekly basis until mid April, by which time Ms D reported feeling better, and said that she had discussed the problems with Mr E. The family were now preparing to move to London.

7.3.2 In July 2007 Child B was admitted to hospital for a day, having suffered body and facial twitching. He was then admitted twice more in August, on the second occasion with generalised fitting. Treatment with anti-epileptic medication was commenced. In October 2007 the family are reported to have moved to an address in the London

Borough of Bexley. Child B was taken by ambulance to Hospital 2 for the first time on 1st November 2007 and his medical oversight was now transferred to the new locality.

7.3.3 Child B continued to have frequent seizures, sometimes managed at home and on other occasions requiring admission to hospital, including admissions in status epilepticus[3], throughout his life. From this point they are not all detailed in this chronology, nor are the frequent reviews of and changes to his medication.

7.3.4 A Health Visitor (HV) made a "moving in" visit on 23rd November. Child B was playing with age appropriate toys, crawling, eating well and had a good sleeping pattern. Child C was sociable and they played well together. No bruising or marks were seen. Ms D said that she was finding it difficult to cope with Child C, who was "clingy" and she sometimes hit him. She was finding it difficult to control her anger. The HV told Ms D that she would need to refer the matter on to Children's Social Care (CSC) and Ms D accepted this. The referral was made that day. The HV thought that Ms D would benefit from a referral to the Children's Centre in order to get some support with her parenting and to meet other parents, and so that the children could socialise with others, and that referral was made a few days later. The HV also contacted the previous locality to discuss the family (although transfer of records was not arranged until some time in 2008).

7.3.5 From mid-December the HV service contacted CSC a number of times to "chase up" the referral, and supply further information. CSC eventually made arrangements to follow up and a social worker visited in mid-January. She subsequently recorded observing good interaction between both parents and the boys. She further noted that she found the parents caring and concerned for the children. The boys themselves were described as friendly and relaxed. It was agreed that there should be no continuing contact from CSC. (CSC had made routine agency checks and the response from the family GP was received after the case had been closed but did not raise any new matters of concern).

7.3.6 The following day Child B was seen by a Consultant Paediatrician at Queen Elizabeth Hospital for an outpatient appointment. Various investigations were arranged and instructions for A&E on seizure management were recorded but overall he was found to be making good developmental progress. The HV made a routine visit around this time and noted that both children were friendly and apparently well cared for. Mr E was asleep, having been out working till 1:00am, and Ms D mentioned that she was thinking of returning to work. Between February and October 2008 Child C attended a local playgroup on a roughly monthly basis and no issues of concern were noted.

7.4 March 2008 – March 2009

7.4.1 At the end of March Child B was taken to A&E at Queen Elizabeth Hospital in status epilepticus, but recovered and was sent home. At the beginning of May Child B had particularly serious seizures, causing him to be admitted to Hospital 2 and then transferred overnight to Paediatric Intensive Care at another hospital. Medical staff were now particularly concerned because the seizures had been prolonged. Child B

[3] Status epilepticus is a serious, life-threatening medical emergency, broadly defined as a prolonged seizure or a series of seizures without regaining consciousness.

had a number of further emergency admissions to hospital following or during seizures and, in September, after further tests, Dravet's Syndrome[4] was diagnosed.

7.5 April 2009 – March 2010

7.5.1 In April 2009 a HV carried out a full review of the children. Child B was described as an active child, slightly overweight, who walked with a wide gait, toes inwards and his head tipped down. The HV did not hear any real speech but he expressed himself with a few sounds and Ms D seemed able to interpret and understand his needs. He seemed to relate well to both parents and was said to sleep well, in their bedroom as they wanted to be able to observe him for fits. However Ms D said that she was concerned about his development and also complained at her own isolation as she had no family in this country. The HV's plan for Child B was to refer him to Speech and Language Therapy (SALT) and the Community Consultant Paediatrician, and explore day care options and she followed all these actions up without delay. He started attending some Children's Centre sessions in June.

7.5.2 Child B was reviewed by paediatricians in June, when his parents expressed their concerns at his slow development and the frequency of seizures – usually two or three a week and sometimes several in one day. He now had reduced muscle tone and unsteady gait. Health management advice was given and he was again referred to the community paediatricians (although it seems that this referral was made to the wrong locality – Greenwich when the family lived in Bexley – and was consequently not followed up).

7.5.3 The next medical review was in September. A change in seizure pattern was noted, from prolonged (45-60minute) seizures to shorter episodes, typically lasting 5 minutes. Drop attacks had stopped but there was no progress in his development and regression in some areas. Changes were made to his medication.

7.5.4 Later that month he was assessed by the Community Consultant Paediatrician who confirmed

- delay in different areas of development but mainly in speech and language, cognitive and self care skills
- seizures which were quite resistant to anti epileptic drugs
- clumsy and drooling presentation.

The Community Consultant Paediatrician recommended physiotherapy, paediatric occupational therapy, SALT and Portage[5], and for review in 6 months.

7.5.5 The family had been referred to specialist Epilepsy Nurses, but had not responded to contact from them. They did bring Child B to an outpatient appointment in October but not, in November, to a regional epilepsy clinic to which he had been referred. He again attended an outpatient clinic in December where hyperactive behaviour and aggression were reported.

[4] See Paragraph 8.1.3 below
[5] A structured system to help parents of children with learning difficulties become effective teachers of their own children.

7.5.6 When next seen in January seizure control had improved following a change in medication but his developmental delay was increasingly noticeable. Paediatric review in February found him more socially interactive and able to use a few simple words. Child B was now attending an opportunity playgroup (a specialist playgroup for children with disabilities), SALT and Portage and, around this time the process of assessing his educational needs commenced with a visit from an Educational Psychologist.

7.6 April 2010 – December 2010

7.6.1 The formal statutory assessment of special educational needs commenced in April and Ms D took Child B to visit the school he might attend. Child B was reviewed in April by the Community Consultant Paediatrician, who noted that his seizures were less frequent but that his developmental delay was getting worse.

7.6.2 In May, Child B was again reviewed by the Community Consultant Paediatrician and at the regional epilepsy clinic. His medication was altered and a helmet was ordered, in view particularly of his starting school later in the year. The order for the helmet went astray and it was not until Child B started school that this was picked up. The statutory special educational needs assessment process took its course and it was agreed that he should attend School K from September. In July, Ms D contacted the SEN service and notified them that she was moving to a different address. She transferred to a new GP and health visiting records were transferred accordingly. A HV called on her at the new address – the final contact from the Health Visiting service - and she confirmed that she was now separated from Mr E.

7.6.3 Both children started school in September. Child B was taken to school by taxi and brought home by bus. He was not accompanied by a parent, although an escort was provided on the transport to and from school. At first he attended mornings, then switched at his mother's request to afternoons, as this made it easier for her to collect his brother from school. He is described by the school as happy, lively and mobile but with a tendency to fall. He tended to engage with adults more than children, and could indicate what he wanted and get attention by a direct approach to adults - putting arms round their legs or their arm.

7.6.4 Ms D and Mr E and the children all came to a parents' evening at the school in October, and seemed to interact easily with each other. Over the next two months Child B's school attendance was not regular – he missed some sessions nearly every week.

7.7 December 2010

7.7.1 A review meeting was held at the school in December but neither parent attended or offered any explanation for their absence. On 9th December Child B had a major seizure at school – the only time this happened – but the school staff were able to manage the situation, and he was back in school the following day, a Friday, taking part in the school play.

7.7.2 Child B did not come to school on Monday but returned on Tuesday, 14th December, when he was seen to have facial bruising. The bruising consisted of 2 linear, symmetrical, vertical marks on either side of his nose and further bruising into his

ears. Teacher X was asked to look at the injuries and agreed with the class teacher that they looked as if they had been caused by contact with bars, such as a stair gate or cot side. Teacher X asked that Ms D be contacted to discuss the injuries, as no explanation had been offered, but Ms D did not answer or return the call made by the school.

7.7.3 The following day a social worker from the Disabled Children Service (DCS) was visiting the school on another matter, and Teacher X spoke to her about Child B. The social worker agreed to check whether the family were known to the local authority and specifically whether there were any child protection concerns.

7.7.4 Teacher X then used the home / school contact book to send the following note
'Also when (Child B) has fallen and is bruised can you just let us know how it has happened as we also have a duty of care and it's important that we are as well informed as possible for all the potential difficulties or accidents

Also I don't know if you have social services input –but if you would like a referral for support it can come/go via the school'.
Ms D replied, using the contact book, to say that they had had a bad weekend with constant falling.

7.7.5 On 17th December the social worker sent the following note to the school
" I have looked him up on the system. He is not known to us, but the health visitor had referred about 2 years ago to West Child Care Team as mother was finding it hard to cope…. If she is willing, I would refer it."

7.8 January 2011

7.8.1 The school then closed for the Christmas holidays until Wednesday 5th January. No agency had contact with the family until that date, when Child B returned to school, and a pattern of occasional absence was resumed – so that he was not at school at least once every week. His absences were explained by his mother as caused by "tiredness". He was in school on Monday 10th January and had an accident, falling and hitting his head, but attended the following day. On the morning of 14th January he was seen with his mother and a man by nursery staff who were conducting an out reach event.

7.8.2 He was absent from school for the whole of the week commencing 17th January. On that date Teacher X telephoned Ms D about making a referral to CSC. Teacher X referred to the marks seen on 14th December but Ms D gave no specific explanation, although she mentioned Child B falling. She was "unsure" about it but agreed that a referral be made to CSC and the referral was made the following day, with a covering note stating that
"This is a request for services and not any other form of concern. Mum reluctantly agreed when I explained about services".

7.8.3 That evening, 17th January, the London Ambulance Service (LAS) responded to a 999 call about Child B having a seizure, apparently the fourth that day – there were reported to have been two seizures in the morning and a third shortly before the one which prompted the 999 call. He was also reported by his mother to have "banged" the side of his face. LAS staff noted that Child B had a possible fracture to right cheek.

Child B was taken to Queen Elizabeth Hospital accompanied by his mother, and seen in A&E. He had bruising and swelling to the right side of his face which was tender and had bitten his tongue. There was no skull injury or swelling, no bleeding from his ears and, after X-rays of facial bones were taken, no fractures were seen. After discussion with the Senior Paediatric Registrar he was discharged.

7.8.4 On Wednesday, 19th January, Ms D telephoned the school, speaking to the secretary, and said that Child B had fallen and had been taken to A & E, with a suspected fractured cheek. On the same day the teacher X telephoned CSC, leaving a message that

"Child B has fallen again in a seizure and Mum is upset about it. I think she could do with some support".

7.8.5 A letter was duly sent to the parents by CSC (apparently on the assumption that they lived together) offering an appointment in a week's time. On each of the next two days, as she had missed the call on 19th January, teacher X telephoned Ms D and left a message for her.

7.8.6 On Friday afternoon, 21st January, the LAS attended Ms D's home in response to a 999 call. Two Fast Response teams, two ambulances and a senior officer were sent, the first arriving within six minutes, as it had been reported that Child B was not breathing. Ms D said that Child B had been put to bed, fatigued & post-ictal[6] following an earlier seizure. She later heard gurgling and on investigation found him in cardiac arrest. Ms D had started cardiopulmonary resuscitation under instruction from the 999 controller and this was continued by the ambulance crew. Child B was intubated and taken by ambulance to Darent Valley Hospital without delay. The ambulance crew also notified police who came to the hospital.

7.8.7 When Child B arrived at hospital he showed no signs of life. Resuscitation continued while information was sought from parents. Both parents were in attendance, Ms D giving information while Mr E was distraught and taken to the parents' room – but Child B was pronounced dead. He was assessed after resuscitation ceased and a number of injuries were identified. The Coroner's Office was informed of the death and the situation was also referred to Bexley CSC, again without delay. The designated paediatrician at Darent Valley Hospital noted that Child B had 14 separate areas of bruising, and reported that he had received hospital treatment for an injury a few days previously. The doctor's initial advice to CSC and police was that the injuries appeared to be non-accidental.

7.8.8 Following initial assessment and scene preservation police commenced an investigation. They arrested Ms D and, during the following week, YPF, when Ms D disclosed their relationship to police.

7.8.9 The following day Child C was brought by his father and paternal grandparents for a medical examination, to establish whether there was any evidence of physical ill-treatment. No concerns were identified.

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[6] *The postictal state is the altered state of consciousness that a person enters after experiencing a seizure. It usually lasts between 5 and 30 minutes, but sometimes longer in the case of larger or more severe seizures and is characterized by drowsiness, confusion, nausea, hypertension, headache or migraine and other disorienting symptoms.*

7.8.10 A post mortem examination was carried out at Great Ormond Street Hospital on 25/01/2011 and found thirty six separate injuries to Child B's body. A skeletal survey showed a fracture of the right tibia, bruising to the liver and a significant bleed to the brain.

7.8.11 Ms D and YPF gave inconsistent and conflicting accounts of the events of the days before Child B's death. Ms D accepted a police caution for perverting the cause of justice in relation to what she had told police. YPF was convicted of manslaughter.

8. THE FAMILY

8.1 Child B

8.1.1 Child B's grandfather has described how Child B was generally a happy child except when he was affected by seizures, which could be severe and leave him unwell for up to a couple of days. This is very much the picture that emerges from the accounts submitted by those agencies who knew him.

8.1.2 Child B is described by his class teacher as having been a happy, "lovely" boy, giggling and cheerful, who rarely cried or became upset at school. Due to his liveliness, tendency to run and move around and climb, he did need close adult supervision at all times because he was at risk of falling. He also had an unstable gait which again meant he frequently fell. He received 1:1 attention much of the time when at school.

8.1.3 Child B had an unusual and challenging medical condition, Dravet's Syndrome, also known as severe myoclonic epilepsy. This is a rare condition with a poor prognosis[7]. It appears during the first year of life with frequent fever-related seizures. Later, other types of seizures typically arise, including myoclonus (involuntary muscle spasms). All patients are cognitively impaired (severely in 50%) but without deterioration after the age of 4 years.

8.1.4 Children with Dravet's Syndrome typically experience poor development of language and motor skills, hyperactivity, and difficulty relating to others. As children with Dravet's Syndrome get older, their decline in cognitive function stabilizes, and in many, it improves slightly. However, most teenagers with Dravet's Syndrome are dependent on carers. The degree of cognitive impairment appears to correlate with the frequency of seizures. Seizures often reach status epilepticus, which is frightening to witness and requires emergency medical care. Seizure control is difficult. The mortality rate is high.

8.2 Child C

8.2.1 This Review has found no cause for concern about Child C. He now lives with his father.

[7] Epilepsy Action advises that seizure control is usually difficult throughout childhood and children with Dravet's Syndrome will need life-long care.

8.3 Ms D

8.3.1 Before the conclusion of the criminal proceedings Ms D did not respond to invitations to meet those involved in the production of this report. She did contact the Safeguarding Board after being approached by the national press and said that she was aware of and understood the need for the SCR process. However she did not then respond to a renewed offer to contribute to this report. After the criminal proceedings she did agree to meet the author of this report, to be advised of its content.

8.4 Mr E

8.4.1 Mr E did meet the author of this report and a member of the SCR Panel while the report was being produced. He was accompanied by his father. They were both still clearly struggling to understand the death of Child B, and raised a number of questions about his care at Hospital 2 on 17th January 2011. They had previously known nothing of the relationship between Ms D and YPF. It was not clear at that time that they were aware of the injuries to Child B in December 2010 – they made no reference to this.

8.4.2 Mr E said that he had found Child B's school very helpful and informative and thought that Child B was definitely benefitting from his attendance there. He had no knowledge of the Disabled Children's Service and the sorts of support they might be able to offer the family of a child with such a significant disability.

8.4.3 Mr E and his father also agreed to meet the author of this report, to be advised of its content, after the criminal proceedings.

9. THE AGENCIES

9.1 Oxleas NHS Foundation Trust

9.1.1 Oxleas was involved as a provider of community health services from July 2010, following merger with the previous provider organisation, the Bexley Care Trust, which was responsible for the family's community health services on their move to London in 2007. Oxleas has also considered information from the PCT covering the area where the family lived before moving to London,.

9.1.2 The first contact with community health services in London was in November 2007. This was the standard initial Health Visitor contact for a family newly moved into an area. As detailed above Ms D disclosed some difficulties which the HV referred to CSC and, after some unsatisfactory delay, a social care assessment was undertaken. This did not lead to any continuing involvement with CSC. The HV had not yet received records from the previous locality so was unaware of the previous concerns for Ms D's health.

9.1.3 After this incident there was relatively little contact between the family and community health services. I think the IMR is correct in commenting on the service's passive response to a family with a child with such a significant disability:
"none of the 3 HVs interviewed had referred the family to the Bexley Disabled Children's Service nor had they asked Ms D if she was known to the team".

Two of the HVs assumed incorrectly that this link had already been made. This is discussed further below.

9.1.4 All the HVs concluded that the parents, and in particular Ms D, with whom they had the greatest direct contact, had come to terms with Child B's disability. This seems a short-sighted approach, particularly taking account of the nature of his diagnosis. As discussed above, Dravet's Syndrome is a rare and profoundly disabling condition, with increased probability of accidents, infection, status epilepticus, and Sudden Unexplained Death in Epilepsy (SUDEP).

9.1.5 It would have been appropriate, at an early stage, to use the Common Assessment Framework[8] to initiate a process of better understanding and responding to the difficulties in the family. Although the CAF was then in its early stages of implementation, relevant staff had been trained and the circumstances of the family clearly indicate that they might need additional input and support. The SCR Panel accepted advice from local agencies that the CAF process was now, some four years later, much more firmly embedded locally, and that it was more likely that a CAF would have been initiated.

9.1.6 The Health Visitors' failure to respond appropriately to the family's situation is identified and addressed in the IMR which concludes that
"HVs involved with families where there is a child with a disability should consider the increased vulnerability of disabled children and have a working knowledge of what services Bexley Disabled Children's Service could offer".

9.1.7 The HV service had no significant involvement in the circumstances around the death of Child B. After his hospital treatment on 17th January the liaison health visitor based at Hospital 2 routinely notified the community-based HV, who put a note in her diary to telephone Ms D on Mon 24th January 2011, by which time Child B had died.

9.2 South London Healthcare Trust (SLHT)

9.2.1 South London Healthcare NHS Trust is the product of a merger of Queen Elizabeth Hospital NHS Trust Woolwich, Bromley Hospitals NHS Trust and Queen Mary's Hospital NHS Trust Sidcup in 2009.
The IMR explains that Child B was known to various services within the South London Healthcare Trust (SLHT) as follows:
"He attended Queen Elizabeth Hospital Accident & Emergency Department on numerous occasions with seizures and was followed up regularly in the Paediatric out-patient department in Queen Elizabeth Hospital by a Consultant Paediatrician with a special interest in epilepsy. Children's Community Services were involved as he had special needs because of his developmental delay. He was reviewed by a Consultant Community Paediatrician and received therapy from Speech & Language Therapy, Portage and Physiotherapy".

9.2.2 SLHT had contact with Child B which is significant to some of the specific Terms of Reference for this Review and this is considered below. His "routine" contact with SLHT services consisted of repeated presentations at A&E, because of seizures, and

[8] The Common Assessment Framework is an assessment tool for use across all children's services in England. It aims to support early identification and assessment of need and to promote co-ordinated service provision. CAF's should be the baseline assessment tool for identifying any additional needs in a child and accessing early intervention and targeted services

continuing contact with specialist epilepsy services. The IMR notes that, as a result of administrative error, he was without a future outpatient appointment at the time of his death. This error was aggravated when he was seen in A&E a few days before his death and the fact that he did not have a future outpatient appointment was not picked up. The report identifies this as a systems weakness which could recur, and makes an appropriate recommendation.

9.2.3 No issues arise in respect of the continuing medical management of his condition, which was led by practitioners with substantial specialist expertise. However, there is no indication from this report that any consideration had been given by medical staff to the support needs of a family caring for a child with such high care needs. Outside the specialist setting Child B was being seen by community health and therapeutic services but there is no evidence that the support needs of his parents were considered. This lack of alertness to the broader needs of disabled children and their families is common across the health services considered in this Review and there is consequently a recommendation to address this concern.

9.2.4 Child B was last seen by the Community Child Health Services on 20th April 2010. His mother expressed concern regarding head injury as a result of fits and requested a protective helmet. A helmet was ordered but had not been fitted before his death, 9 months later. This was investigated in the process of this Serious Case Review. It was established that the original request from the paediatricians was not sent as a discrete referral but was mentioned in the body of a letter, and was not picked up as requiring action. When Child B started at school his mother raised this again and the matter was resolved by the school physiotherapists. SLHT, the body now responsible for this service has indicated that this will be raised as a learning point with the appropriate staff.

9.2.5 The family had contact with speech and language therapy services (SALT) but there is no evidence of any communication between SALT and the HV service and vice versa.

9.3 The General Practitioners

9.3.1 Child B was seen on very few occasions by his GPs, which is not unusual for those who have substantial contact with hospital-based medical services. As the GP records contain mainly 3rd party information in the form of letters and reports from hospitals, it was agreed that it would be appropriate for information to be provided to this Review in a report rather than a full management review. That report has been compiled by Bexley's Designated Doctor for Safeguarding Children.

9.3.2 The only issue picked up as significant to the analysis of these events is that, as the report describes

"Whilst (Child B's) medical needs were seen to be well addressed, GPs who came in contact with the family did not consider the holistic needs of the family. There is no evidence as to whether the GP had a discussion with Ms D and Mr E of the impact of caring for Child B. GP's were not sufficiently curious about the home situation".

9.3.3 As with other health services, there is little evidence to suggest that the GPs were alert to the demands of caring for a child with a profound disability, over and above the medical management of the situation. There were missed opportunities for services to work together more pro-actively to support the family.

9.4 NHS South East London: Health Overview Report

9.4.1 The purpose of the Health Overview Report is to evaluate and comment on the health services involved in the case under review, serving also as the IMR for the commissioners of health services provided, NHS South East London. The report considers the full IMRs submitted by

- Oxleas NHS Foundation Trust Community Provider Unit (CPU)
- South London Healthcare NHS Trust (SLHT)

9.4.2 In addition reports from the following health service agencies were considered:

- London Ambulance Service
- GP services
- Dartford & Gravesham NHS Trust

9.4.3 The report summarises the key learning points for the health agencies involved:

- Child B's complex medical needs were largely well met by general and specialist health services.
- Those health services did not all pay adequate attention to the family's wider social circumstances.
- The management of Child B's presentation at Hospital 2 on 17th January completely missed the possibility that his injuries might be inflicted.

9.4.4 The following excerpt from the Health Overview Report captures the key issues:

"It is evident in all the health IMRs that staff working with the family were sensitive to the medical and therapy needs of Child B and ensured that these were addressed. Health agencies concentrated almost exclusively on Child B's physical and learning abilities and difficulties. This was done in almost total isolation from the context of his family, parenting, home background and experience".

9.5 Child B's School

9.5.1 Child B's parents had initiated the statutory assessment of his Special Educational Needs in February 2010, and that process had been completed without incident in July. His mother had visited their preferred school in April and arrangements were made for his admission, part-time, in September. Both parents attended a parents' evening in October and Ms D remarked on how pleased she was with the school and Child B's progress. In mid-December Child B was seen at school with facial injuries. Child B was absent from school approximately three to four days each month until January when it increased. He was absent from school for the whole of the week before his death.

9.5.2 The IMR notes that, with hindsight, there may be indications of cause for concern, or change in circumstances, in December. For the first time, Child B had unexplained absence from school. In the same week his parents did not attend a pre-planned Review meeting at school. Neither parent is recorded as attending a school play. On 13th December he did not come to school. His mother, without any notice, rang and said that he had a medical but this explanation is not corroborated in the information submitted to this Review. On 14th December he had the facial injuries discussed in Section 10.2 below.

9.5.3 The IMR is very full, providing a helpful picture of Child B, and identifies a number of important learning points. Largely these are addressed in Section 10 of this report which addresses the specific Terms of Reference for the Review. However the report also draws out some important issues about administrative arrangements within the school and about school transport arrangements for very young children with a statement of special educational need.

9.5.4 The school had not been sufficiently thorough in establishing Child B's home circumstances. Although Ms D had given separate addresses for herself and Mr E, this had not been picked up and explored by staff, so that they were not adequately informed about the family background. As the IMR points out, the possible consequences of this information – for example, that Ms D might be less well supported at home - should have been taken into account as the school became more concerned for the child. Even setting aside the serious concerns arising from this case, it is not adequate for the school to be in the position described below in the IMR.
"What is missing is an accurate picture of the child as he is in his family, an accurate description or knowledge of who lives at home and who provides care to Child B. There is no description of support provided to the parents… (of) an active child with limited communication. No information is recorded on parents' occupations, any other social or family support or activities. Nor is there any description of the family or accommodation. This is reported as not unusual for any children at the school."

9.5.5 The IMR also notes the arrangements for Child B's journey to school.
"Whilst appreciating that these arrangements are commonplace for children with statements of Special Educational Needs the author questions whether this meets the emotional needs of such young and vulnerable children with such limited communication ability".

9.5.6 As the IMR author states these arrangements are not unusual but I think it is appropriate that they be highlighted and they give rise to recommendations from this report. A particular consequence is that school staff never saw Child B in the company of any members of his family, and were not easily able to develop any relationship with his parents.

9.6 London Borough of Bexley, Children's Social Care Services

9.6.1 Bexley Children's Social Care Services (BCSC) were involved with this family twice. The first time was when a HV made a referral in November 2007, after carrying out a "moving in" visit following the family's move to London. BCSC's response to this referral was slow and there was some confusion between social workers and day care providers about who was to respond. A home visit was eventually made in January 2008 and it was agreed with the family that there was no need for continuing involvement. The family kept in touch with a Children's Centre, to which the Health Visitor had referred them, until the summer of 2009. Child B was coincidentally seen by Children's Centre staff, at an outreach event, a few days before his death.

9.6.2 The only other involvement of BCSC in this case was the discussion between a social worker from the Disabled Children's Service and Teacher X at Child B's school, shortly before his death, and the matters arising from that. This is considered below.

9.7 Greenwich Children's Services

9.7.1 GCS have had no involvement with Child B or any members of his family, and are only involved in this Review because of their contact with YPF, which came to an end in 2008. This Review has not received any evidence of contact between YPF and Child B, or any member of his family. It was only after the death of Child B that the relationship between YPF and Ms D was known to any of the agencies involved in this Review. Consequently GCS are not in a position, in their report, to address many of the matters identified in the Terms of Reference for this Review.

9.7.2 The report does comment on the nature, quality and effectiveness of the intermittent contact between GCS and YPF between 2003 and 2008, suggesting that his "complex and extensive family history" might have been taken more fully into account in shaping services provided. It is clear that YPF had a troubled family background and was himself demonstrating worrying behaviour at home. His educational needs were assessed and his special school provided a supportive environment. He attended school on a regular basis and the Head Teacher said that YPF was bright and articulate. He was not identified as being aggressive at school. No specific concerns were identified by the school in the period after contact with children's social care ceased. Agencies did work together but found it difficult to secure positive change in family relationships.

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9.7.3 Since 2008, there has been no evidence of continuing cause for concern for YPF and GCS received no referrals during this time. He has come to police attention only twice in that period, once as an alleged victim of crime. His school generally speak well of him and there have been no concerns about him.

9.8 Metropolitan Police Service

9.8.1 The Metropolitan Police Service (MPS) have had no significant contact with Child B or any members of his family before his death. Consequently there are no significant issues arising from the MPS input to this Review. The IMR is in line with the standard model used by the MPS and fully addresses the issues raised in the Terms of Reference, to the limited extent that they are relevant to police.

9.9 Background Reports

9.9.1 The following agencies had a limited involvement with this family and submitted reports containing background information:

- London Ambulance Service
- Dartford & Gravesham NHS Trust
- London Borough of Bexley, Statutory Assessment Service
- Child C's school
- Bexley Children's Centre Service
- Bexley Portage Service

9.9.2 The LAS were called on 16 occasions when Child B had seizures and on the day of his death. On each occasion he was taken to Hospital 2 except on the day of his death

when he was taken to Hospital 1. The report indicates that the management of the 999 calls and the care provided by the attending ambulance staff were satisfactory. The report picks up two learning points for the service, which will be followed up, although they did not significantly affect the management of this case:

- There were no advance care plan arrangements, agreed with the patient, relatives and the health and social care professionals, which may be held against a patient's address on the 999 call taking system.
- There is no systematic means of identifying repeat calls to the same address in relation to children.

9.9.3 There are two reports from Hospital 1. The first describes the presentation and death of Child B, detailing fourteen areas of bruising found and concluding that
"Some of these are unusual of accidental injuries (and)… may have been caused non accidentally".

The second report follows from a medical examination of Child C, conducted under child protection arrangements after the death of his brother. This report found no cause for concern about Child C who
"had an excellent interaction with his father…of a playful and caring nature".

9.9.4 The report from the Statutory Assessment Service describes the arrangements for assessment of Child B's special educational needs and allocation of a special school place. It seems to have worked smoothly and raises no concerns.

9.9.5 The report from Child C's school indicates no cause for concern.

9.9.6 The Children's Centre service knew the family as a result of the Health Visitor's referral in 2007. The family attended Children's Centre events, approximately monthly, over some 18 months, and there were no subsequent causes for concern about their welfare.

9.9.7 A Senior Portage Home Visitor carried out four home visits, seeing Ms D but not Mr E on each occasion, and saw Child B once at the Opportunity Playgroup. She did not witness anything that caused any concern and always found the children to be
"well cared for and loved by Ms D".

9.9.8 The SCR Panel noted that the Portage Service in Bexley is based with and linked in to the Disabled Children's Service, so that there would have been a straightforward way for a referral to be made to the Disabled Children's Service, had there been any concerns.

10. SPECIFIC ISSUES IDENTIFIED IN THE TERMS OF REFERENCE

10.1 Introduction

10.1.1 The previous section of this report summarises the agencies' responses to the "standard" SCR issues, as detailed in the government's guidance, "Working Together". Agencies were further asked to consider issues identified as specific to this case, as detailed below.

10.2 Child B was seen at school with facial injuries in December 2010. Did the action taken by the agencies and professionals involved meet his assessed needs?

10.2.1 Child B did not come to school on Monday,13th December but returned the following day, when he was seen to have facial bruising. This was the first time he had come to school with any evident bruising. It consisted of 2 linear, symmetrical, vertical marks on either side of his nose and further bruising into his ears. Teacher X was asked to look at the injuries and agreed with the class teacher that they looked as if they had been caused by contact with bars, such as a stair gate or cot side. Teacher X asked that Ms D be contacted to discuss the injuries, as no explanation had been offered, but Ms D did not answer or return the call. A handwritten note was sent home with the child by a Teaching Assistant, asking about the facial injuries. No copy of that note was kept. In recording the matter on that day, in response to the prompt
'Is the concern considered to be safeguarding?"
the school records state
"Some concerns".

10.2.2 Child B came to school as usual the following day, 15th December. There was still no explanation for the injuries. At the end of the day, a teacher wrote in the home / school contact book, as follows:
'Also when (Child B) has fallen and is bruised can you just let us know how it has happened as we also have a duty of care and it's important that we are as well informed as possible for all the potential difficulties or accidents.
Also I don't know if you have social services input –but if you would like a referral for support it can come/go via the school'.

10.2.3 Towards the end of that school day Teacher X had a conversation with a social worker from the Disabled Children's Service, who was coincidentally in the school. There is some variation between the accounts given to this Review by those involved in that conversation. Teacher X does not recall that the conversation included any reference to safeguarding but that there was a general discussion about Child B's background, including a susceptibility to falling. The social worker's account is that Teacher X raised the issue of the child's injuries, said that they might have been caused by falling against a stair gate, and specifically stated that she was not making a child protection referral. The social worker recalls that she advised that, if they were not concerned about the cause of the bruising, they should refer to the Disabled Children's Service who would make an assessment of what services could be offered to the family. The social worker agreed to check the system to see whether Child B was known to their service.

10.2.4 The school cannot be clear about the exact date – it was either Wednesday 15th or Thursday 16th December – that there was a note from Ms D, in the home / school contact book referring to a "bad weekend" with "constant falling". Again the school cannot be clear about the date but report that on one of those two days they received an email from the DCS social worker, which the school describe as "*confirming Child B not on CP (Child Protection) Plan*". The account given by CSC is that an email was sent by the DCS social worker on 17th December[9], stating that

" I have looked him up on the system. He is not known to us, but the health visitor had referred about 2 years ago to West Child Care Team as mother was finding it hard to cope… If she is willing, I would refer it."

10.2.5 The school closed for Christmas on 17th December and it was not until 17th January that Teacher X followed up the issue of referral to the DCS. On that day she contacted Ms D and referred to the marks seen on 14th December but Ms D gave no specific explanation. Ms D agreed that a referral be made to the DCS. Teacher X sent the following referral on 18th January (the day after Child B had been treated for injuries at Hospital 2, of which Teacher X was unaware):

"I am attaching a referral form for Child B (Do you remember we spoke about him before Christmas?) This is a request for services and not any other form of concern. Mum reluctantly agreed when I explained about services".

10.2.6 It is clear that there were a number of unsatisfactory aspects to the management of these events. There is no evidence to corroborate the assertion that Child B's absence from school on Monday, 13th December was because of a "medical". In themselves that absence and explanation do not necessarily give cause for concern. The school IMR comments that

"The school were unaware of the nature of this medical but this is not uncommon as unfortunately they are not sent copies routinely nor invited to any medical reviews, even when held at the school".

However, this explanation for his absence remains unsubstantiated. None of the agencies involved in this Review have been able to confirm that any "medical" took place.

10.2.7 The facial injuries were unusual in themselves and were the first such injuries seen in Child B at school. When discussed by the SCR Panel, the following advice, from a Panel member with a nursing background, was noted:

"a direct fall could result in some symmetrical bruising, but not in the linear nature which stretched back to the ears, as observed on Child B. The explanation suggested … of a fall onto a stair gate did not seem plausible".

The injuries were never referred for medical investigations. This was a missed opportunity in itself. As the IMR notes

"A parent might have been expected to make contact and explain such unusual marks-they did not".

10.2.8 The lack of response from Ms D to the school's attempts to discuss the facial injuries was also unusual – there were two phone calls and two entries in the home/school contact book before Ms D responded, in contrast to her swift responses to previous communications. The school had not established that the child's parents had separated so that no attempt was made to contact Child B's father.

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[9] CSC have submitted a copy email which appears to confirm that their account of events, dating the email at 17th December, is accurate.

10.2.9 In relation to discussing her concerns with the visiting social worker, Teacher X *"recalls a reference to safeguarding (but) she does not remember any suggestion from the social worker that she should make a safeguarding referral at that time"* (Education IMR)

Teacher X was the designated lead professional for safeguarding within the school, and should not have needed to rely on the social worker's direction. In fact, the social worker reports that the injuries were discussed and Teacher X specifically stated that she was not making a child protection referral.

10.2.10 Teacher X reported to the Review that she had worried about Child B over the Christmas break. That "instinctive" concern, especially from a very experienced professional, should not be disregarded. However, her failure to take the next step and make a referral persisted right up to the point in January when she did so. That referral does not mention the injuries noted in December, and the absence of a satisfactory explanation for them, even though she had discussed the injuries with Ms D the day before, when obtaining her consent for the referral. The referral also states that there are "no welfare concerns" – which presumably means that there are no concerns for the child but that the mother would benefit from support.

10.2.11 Reluctance to refer is not uncommon. NSPCC research[10] has found

"There was considerable variation between and within …schools in their willingness to report concerns. This was influenced by several factors including the relationship with parents, uncertainty about the level of evidence required, and the approach of the head teacher"

10.2.12 There can be other factors specific to disabled children. Schools often have particularly strong and caring relationships with the families of disabled children. They also often have good informal relationships with specialist social workers – in this instance, teacher X took the opportunity of speaking with the specialist social worker who was visiting the school on another matter. The CSC IMR notes

"The DCS social worker said it was not uncommon for special schools to have conversations about children in an ad hoc way as they get to know the DCS social workers well and so will have passing conversations, when the opportunity arises".

10.2.13 However, Teacher X may have allowed herself, to some extent, to have been falsely reassured. There is a need to strike an appropriate balance so that informal discussion assists school staff in making appropriate referrals rather than inhibits them from doing so.

10.2.14 The CSC IMR takes a strict line, again assisted by the benefit of hindsight, in judging that

"It would have been more effective practice if the school had been referred to the duty service or safeguarding children service (by the DCS social worker), for all the details of the conversation to be recorded at the time".

although the IMR acknowledges that

"from the DCS social worker's point of view …the school had made an assessment themselves and had attributed the bruises to the results of his condition"

[10] Schools, Social Services and Safeguarding Children: Past practice and future challenges Mary Baginsky NSPCC 2007

10.2.15 I am reluctant to be unnecessarily critical of the social worker in these circumstances. It is unrealistic to expect professionals working together not to have informal discussions that assist them in clarifying professional duties and obligations. However, the nature and circumstances of the injury and the absence of any explanation should have been enough to indicate the need for formal referral from the school. The CSC IMR sums the issue up:

"Where there is uncertainty about whether a referral needs to be made the best practice would be for agencies to discuss this with the relevant duty service, or have a formal discussion with safeguarding children service, and social workers need to guide colleagues to follow this route, albeit that agencies may feel that is unhelpful at the time".

10.3 Was Child B's presentation at an Accident & Emergency Department on 17th January 2011 managed appropriately by the professionals involved taking into account both his health needs around his disability and the need to ensure he was safeguarded?

10.3.1 On 17th January, at around 9:15pm, Child B was taken by ambulance, accompanied by his mother and an unidentified friend of hers, to Hospital 2. It was reported that he had had four seizures that day. Ambulance staff noted injuries to his right cheek which were said to have been caused in the course of the first seizure that morning. Staff were told that he had continued to bang the same side during three subsequent seizures. He had swelling and bruising to the right side of his face and bitten his tongue, which was slightly swollen. He was afebrile, with no skull injury or swelling.

10.3.2 He was triaged by a very experienced nurse and then examined by a locum A&E Registrar, as described in the SLHT IMR:

"The head and neck were inspected and palpated for injuries. A 5x5cm haematoma was found over the right cheek. His tongue was swollen, but not impairing his airway. There was tenderness inside his mouth. The chest and abdomen were examined. His clothing was lifted and the skin inspected, the heart and chest were listened to. His abdomen was palpated. His legs were examined by palpation through his clothes, his hands were visually inspected. No other injuries were detected …X-rays of the face were taken to exclude a fracture to the cheek bone. There was no obvious fracture. The doctor was satisfied that Child B had soft tissue injuries only and was well enough to be discharged home with advice, but discussed Child B with the on-call Paediatric Specialist Registrar who was already in the department assessing other children… both doctors were satisfied with the explanation given for the injury and happy for Child B to be discharged home".

10.3.3 The hospital IMR points out that

"The history of the mechanism of injury is definitely plausible. It is well known that patients can injure themselves during seizures as they occur unpredictably without warning, and are often accompanied by violent jerking. Tongue biting and bruises are well recognized injuries following seizures"

10.3.4 It is also right to recognise that no concerns arose from the presentation of Ms D at the time, nor from her observed handling of Child B. There was no history of child protection concerns. Although the A&E Department was extremely busy that day the IMR reports that

"*There is no indication that inadequacies in staffing (were) a factor in the care/service that was received by the family*".

10.3.5 The SCR Panel discussed at length whether, even setting aside any possible safeguarding concerns, it might have been more appropriate to admit Child B to hospital for observation. He was said to have had four seizures in the day and was presenting with what seems to have been a severe facial injury.

10.3.6 In any case, the Panel was even more concerned that the assessment of his presentation, and the decision that he should not be admitted, seems not to have taken account of the possibility that Child B's injuries may have been inflicted. The possible causes of his injuries were not thoroughly explored. Neither was the plausibility of the explanation of them which was offered. In particular:

- The history taken regarding causation of the injuries was inadequate, with no recorded family or social background, and no differential diagnosis.
- Although Child B had been seen in similar circumstances at QEH many times previously, this was the first presentation with injuries of this nature.
- The review undertaken by the paediatrician was unclear and unsatisfactory. Although the assessment of Child B's neurological status, based on X-rays and the report from the A&E doctor, was adequate, the paediatrician did not examine the child, take a history or make an entry in the medical notes.
- There was no documented discharge plan or advice to Ms D
- Overall, there was a lack of "respectful uncertainty[11]" – Lord Laming's phrase reminding those dealing with children of the importance of keeping an open mind about possible child protection issues. There does not seem to have been any consideration here of the possibility of deliberate injury.

10.3.7 That "respectful uncertainty" is particularly important in respect of disabled children, who are known to be more than usually vulnerable to abuse.
"A large scale American study that examined records of over 40,000 children found that disabled children were 3.4 times more likely to be abused or neglected than non-disabled children. Disabled children were 3.8 times more likely to be neglected, 3.8 times more likely to be physically abused, 3.1 times more likely to be sexually abused and 3.9 times more likely to be emotionally abused. Overall, the study concluded that 31% of disabled children had been abused, compared to a prevalence rate of 9% among the nondisabled[12].

10.3.8 Research[13] also points out that professionals may find it more difficult to identify abuse or neglect because of a number of attitudes or assumptions, including:

- Negative attitudes which create both a vulnerability to abuse and make it less likely that disabled children will be heard
- A commonly held belief that disabled children are not abused.
- A lack of awareness among carers, professionals and the general
- public of the vulnerability of disabled children and the indicators of
- abuse for disabled children.

[11] The Victoria Climbie Enquiry (2003)
[12] Sullivan, P.M. and Knutson, J.F. (2000) Maltreatment and Disabilities: A Population Based Epidemiological Study Child Abuse and Neglect, 24, pp1257-1273.
[13] It Doesn't Happen To Disabled Children NSPCC (2003)

- Over-identification with the child's parents/carers
- Reluctance to accept that abuse or neglect might be inflicted on a disabled child
- Behaviours or injuries that may indicate the child is being abused being confused with those associated with the child's disability

10.3.9 In this instance the possibility that Child B's injuries were not caused in the way his mother described was not explored. We can see in the light of subsequent events that it should have been. As the SLHT IMR points out
"The increased vulnerability of Child B to abuse was not considered… The fact that this was not recognised by three experienced and adequately trained professionals points to a more fundamental problem with Safeguarding Training with respect to children with disabilities in general".

10.3.10 The regulators, OFSTED, have on occasion criticised SCRs for failing explicitly to comment on whether the death of a child was preventable. The author of this report does not accept that this is necessarily a helpful expectation. It is reasonable to comment on whether different actions might have led to different outcomes, but that commentary is not necessarily improved by focussing on the death rather than the events preceding the death. It is also important that the purposes of this exercise do not get unnecessarily confused with coronial and / or criminal procedures.

10.3.11 In this case there were two significant missed opportunities, when Child B presented with injuries at school in December and then at hospital shortly before his death in January. The responses of the agencies involved in those incidents were not sufficiently thorough. They should have led to fuller investigations. Those investigations may have identified significant changes in Ms D's circumstances, and may have led to safer arrangements for Child B. The fact that he had a wider extended family that could have become more directly involved in his immediate care could have been important.

10.3.12 In summary, more thorough investigations should have been carried out and may have successfully protected Child B. We cannot know whether such actions would have prevented Child B's death but it is clear that there were missed opportunities to protect him.

10.4 What was the impact of Child B's disability on how his family functioned? Were appropriate support services provided to Child B and his family?

10.4.1 The Terms of Reference for this Review appropriately identify this as an area to be explored. An authoritative report[14] reminds us that
"Disabled children and their families face a unique and often challenging set of circumstances that demand a unique and sometimes specialised response from both the universal and targeted services that support them".
Research[15] has found that

[14] Aiming High for Disabled Children (HM Treasury, Department for Education & Science 2007)
[15] The Every Disabled Child Matters (EDCM) campaign - run by four of the leading organisations working with disabled children and their families - Contact a Family, the Council for Disabled Children, Mencap and the Special Education Consortium.

"Rates of family breakdown are significantly higher in families with disabled children"

10.4.2 Child B had a very seriously disabling condition. That condition presented, among other ways, in his having grand mal seizures, which are always alarming for those witnessing them. It unusually included a regressive aspect, so that his development was in some ways "going backwards" at that time.

10.4.3 This may have been a contributory factor in the breakdown of the parental relationship, though we do not know that. It was not raised by Child B's father when interviewed to inform this report. Child B's paternal grandfather has told us that he was a generally happy child except when affected by seizures and their consequences.

10.4.4 On the other hand it seems clear that the great part of the responsibility for caring for Child B, day to day, lay with his mother, who did not respond to our request for a meeting.

10.4.5 In the absence of any detailed evidence it would not be appropriate to go further than that in commenting on family functioning.

10.4.6 With respect to services provided, Child B had continuing contact with specialist medical input (there was a "glitch" in outpatient arrangements at the time of his death, which requires changes to appointments systems). There was an appropriate plan involving the Child Development Team, physiotherapy, SALT and Portage. His school generally had a good, proactive approach to supporting families. Mr E told us that

"The family …had found (Child B's) school helpful. The school had sent emails about school activities and events. Mr E thought (Child B) was definitely benefitting from being at school".

10.4.7 There was a range of views across the SCR Panel about the involvement of the specialist social work team. Some Panel members felt that the significant and challenging disabilities of Child B should have prompted an early referral, probably by Health Visitors, to the Disabled Children's Service, and that the absence of such a referral suggested an over-medicalised approach to the family. (Two of the Health Visitors involved have reported that they assumed contact from the DCS would routinely be in place). Other Panel members took the view that such a referral would only be appropriate in the event of identification of concerns necessarily requiring social work involvement. The notes of a Panel meeting record that

*"The panel discussed whether there should have been an earlier referral of Child B to the Disabled Children's Service. The general consensus was that Child B was just three years old and had been given a place in a special school nursery with an extensive care package. Since birth he had received support from the health visiting service and children's centre; there was also a considerable amount of medical involvement however, **there had not appeared to be a trigger** (my emphasis) for requesting any additional support other than that already in place.*

10.4.8 In any case, I agree with the Health Overview report which comments that

"when it became apparent (in 2007) that the case did not meet the threshold for a core assessment the health visitor could have usefully considered initiating a

Common Assessment[16] (CAF) and a Team Around the Child approach which would have ensured a holistic assessment of the family's needs and the considered specific issues around the impact of caring for child B".
Health staff were insufficiently proactive when the deteriorating nature of Child B's condition should have indicated the need to plan ahead.

10.4.9 The BSCB Manager has reported that these concerns are being addressed by work already underway in Bexley. This includes

- Simplified multi-agency guidance on thresholds for referral to Children's Social Care and links to CAF assessment to be in place this summer (to be referred to as BEAN, the Bexley Early Assessment of Need)
- Developmental work on safeguarding disabled children, reported to the LSCB Executive in July 2011. This also specifically addresses threshold issues – guidance on when to refer. The LSCB Continuum of Need matrix is to be revised to include more indicators around disability (to be completed this summer).

10.5 Did agencies appropriately balance their responsibilities to support the adults caring for Child B with the requirement to protect him and promote his best interests?

10.5.1 The Terms of Reference for this Review also properly identify this as an area to be considered. Over-identification with adults, with consequent cost for the child, often features as a finding from Serious Case Reviews.
"Everybody working as 'safeguarders' in the safeguarding system, especially those working in the universal services provided by health, education, early years provision and local police, needs to become more aware of the authority in their role, and to use it to safeguard the children as well as to support parents"[17].

10.5.2 Having said that, there is relatively little evidence to justify that concern in this case. There were two important points when issues of child protection arose – in December 2010 when Child B came to school with facial injuries and in January 2011 when he was taken to hospital a few days before his death. The responses of agencies to those presentations and the concerns that arise from them are explored above. However, neither incident gives rise to concerns about an undue emphasis on supporting the adults in Child B's family. Their significance lies principally in standards of assessment, attitudes to disabled children and reluctance to escalate a situation.

10.6 Were there any issues of culture or ethnicity which affected the response of Child B's family to his disability?

10.6.1 There is no evidence that culture or ethnicity had any impact on the family's response to Child B's disability. The reports of those agencies that had any significant contact generally confirm that, before the incidents leading to his death, he was well cared

[16] The Common Assessment Framework is an assessment tool for use across all children's services in England, it aims to support early identification of need and its assessment and to promote co-ordinated service provision. CAF's should be the baseline assessment tool for identifying any additional needs in a child and accessing early intervention and targeted services.

[17] Serious Case Review Executive Summary, Baby Peter, Haringey LSCB February 2009

for within his family. His father and paternal grandfather have been interviewed to inform this report. It was clear that he was dearly loved within his family.

10.6.2 Similarly there is nothing to suggest that issues of culture or ethnicity affected service provision. The Health Overview report suggests that staff may have had a
"lack of understanding of the need to talk about and take into account a child's and family's ethnicity and cultural needs"
pointing out that
"there is research that identifies disabled children and families from black and minority ethnic groups are less likely to receive services they need[18]*.*

10.6.3 However, in this case a Health Visitor appropriately referred the family to a Children's Centre because, as she reported in interview, she recognised that
"Ms D was isolated and (she) felt that this referral would be beneficial to Ms D and the children as it is situated within a multi cultural area of London".
Overall there is no evidence that Child B did not receive appropriate services as a consequence of ethnicity.

10.7 Was Child B able to express his wishes and feelings? How was communication with Child B managed by those working with him?

10.7.1 The SLHT IMR notes that Child B
"was able to say some single words such as "ju" for drink, "woowoo" for all animals and "ball". He was able to cry when apparently distressed, and understood objects in context e.g., "putting coat on meant going out".

10.7.2 The Oxleas IMR advises that Ms D was able to understand his needs although his ability to communicate was extremely limited:
"Child B communicated by pointing and making some vocalisations. If he was unhappy he would scream".

10.7.3 His school, which is best placed to comment on this issue, report that he was
"at an early developmental level and relied on adults to interpret his feelings and emotions".
He was being observed during his first term by Speech and Language Therapy staff, who would then advise and assist in developing ways for staff to communicate with him. The Oxleas IMR picks up that
"there is no evidence of any communication between SALT and the HV service and vice versa… although both were involved with both children at this time and both were part of Bexley Care Trust"

10.7.4 Overall it is clear that Child B's ability to communicate was severely limited. This difficulty was compounded by the deteriorating nature of his condition which meant that after reaching some communications milestones he subsequently lost those abilities.

10.7.5 As a consequence his vulnerability was significantly increased. That was not given sufficient weight on the two occasions, in December 2010 and January 2011, when it

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[18] (Chamba et al, 1999)

might have been appropriate for action to be taken under child protection arrangements.

10.8 Are there any similarities between the key issues in this case and those which have arisen in any previous reviews (including internal reviews and "near misses") to which the agencies in this case have contributed? If so, can the agencies demonstrate that they had learned lessons and taken action to address those issues?

10.8.1 The reports from MPS, Oxleas and Bexley CSC do consider this issue. Police report that

"From a police perspective neither of the (previous) SCRs involved issues relevant to this review".

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10.8.2 The CSC IMR refers to a previous SCR which commented on the practice of social workers making "informal" checks and reporting back to partner agencies, as happened here between school and DCS social worker, rather than requiring the school to make a formal referral. The IMR reports that

"As a result of the previous SCR… all safeguarding checks with Children's Social Care should always be undertaken as a formal consultation with a qualified social worker…".

While this may be established practice in the social work duty teams, it may be necessary to remind specialist teams, such as the DCS, that this requirement also applies to them.

10.8.3 Since 2008 Bexley Safeguarding Children Board has received two previous SCR reports and one "Near Miss" Serious Untoward Incident (SUI) report in which, as with Child B, there have been concerns about the management of children in hospitals. In the SCRs both children had attended hospital shortly before the event which led to the death. In the case of the SUI and one SCR there was a lack of information about adult male partners in the household.

10.8.4 In fact the SUI report also contains other similarities. Most importantly it comments on a

" lack of assessment of the possibility of non-accidental injury in A&E".

It goes on to note the inconsistent implementation of the "Paediatric Injury Checklist" at Hospital 2, and I can find no reference to this in the Hospital 2 IMR to this review, suggesting that its use remains unsatisfactory.

10.8.5 As well as being issues for these individual agencies, the LSCB will need to consider how arrangements for disseminating SCR findings and following up recommendations can be improved.

11. KEY ISSUES ARISING FROM AN OVERVIEW OF THIS CASE

11.1 Child protection and disabled children

11.1.1 In the absence of any recent, authoritative information about those looking after Child B it is difficult to comment on specific aspects of his care. However it is right to note that children with disabilities are at a heightened risk of abuse. The London Procedures (Section 5.11) point out that there are abusive behaviours which apply specifically or particularly to disabled children. As Jenny Morris said 12 years ago:
"Child protection policies and procedures are intended to offer protection to all children, regardless of gender, race or impairment. However, unless specific attention is paid, by those devising and implementing child protection systems, to the particular experiences and particular needs of disabled children, they will continue to remain invisible within child protection systems. It will therefore remain unlikely that disabled children will be accorded the full protection from abuse which is so needed". [19]

11.1.2 There are dilemmas for staff. They may be unwilling to challenge a parent who is responsible for the hard work and commitment of caring on a daily basis. Staff may be too ready to accept that a carer is "doing their best" and may consequently accept a sub-standard level of care. However there is extensive research which underlines the particular vulnerability of disabled children and the barriers, both organisational and attitudinal, to effective protection within current systems. That vulnerability, and the need to maintain awareness of it, is the key message arising from this Review.

12. COMMENTS ON SERIOUS CASE REVIEW PROCESS

12.1 Compliance with guidance and timescales

12.1.1 This SCR was conducted efficiently. There were no undue delays or difficulties and it was completed on time.

12.2 Good Practice

12.2.1 The Education IMR author felt it appropriate to submit an annexe to her main report, giving a very informative insight into Child B's school. This helpfully balances any tendency to dwell on mistakes and missed opportunities. She describes
"a bright and well furbished building…(where) classrooms each have pupil groups of 6-10 and 3-7 staff …(and are) well equipped with both learning, play and comfort/care facilities… The atmosphere and environment …was always calm, warm and welcoming …(with) staff (who) were clearly kind and caring towards the children…(and a) Head Teacher (who) knows in detail the various individual children's support needs and abilities and their particular circumstances and progress in the school".

12.2.2 Otherwise OFSTED[20] has suggested that the "best" SCRs will identify

[19] Jenny Morris, Disabled children, child protection systems and the Children Act 1989.

[20] OFSTED SCR Descriptors January 2009

“Good practice… with appropriate consideration of its potential for wider implementation”.

The Review did not find any further examples of good practice that meet this definition.

13. CONCLUSIONS: LEARNING POINTS AND MISSED OPPORTUNITIES

13.1 Child B had a severely disabling medical condition with a poor prognosis. He required continuous close attention and frequently needed to be taken to hospital by emergency services. Looking after him will have been physically and emotionally demanding. His medical care was generally good but little attention was given by health agencies to other supports for him and those caring for him. A Common Assessment Framework evaluation of their additional needs would have been appropriate.

13.2 There were early indications that Ms D's health could be fragile. After the relationship with Mr E ended in 2010 she was in a vulnerable position, in insecure accommodation, far from home and family support, with all the day to day responsibility for Child B and his brother. She became involved in a covert relationship with YPF. This relationship was not known to any of the professionals or agencies contributing to this Review.

13.3 Before December 2010 there were no specific concerns for the care provided to Child B. However, Child B's school should have had more reliable arrangements for maintaining accurate basic information about pupils' family circumstances. The IMR also found cause for concern about such a young child being transported to school without a parent or known carer. Despite these concerns, it is right to note that there are many positive aspects about this school's approach to educating and looking after children with significant disabilities

13.4 When Child B came to school with unusual facial bruising, and Ms D did not respond to enquiries about this, the school should have recognised that this might be a child protection matter. They should have made a referral to CSC for investigation. There were weaknesses in the school's recording and follow-up of their concerns so that, when a referral was eventually made to CSC, a month later, it did not specifically refer to the facial bruising. Teacher X was the lead officer for safeguarding in the school and should have been clearer and firmer about the need for a safeguarding referral.

13.5 Teacher X did discuss concerns about Child B informally with a social worker from the DCS, who happened to be in the school. In some ways this discussion served to deflect attention from the need to make a safeguarding referral. It can be difficult for specialist social workers, who have frequent contact with schools, to ensure that discussions do not become a way of obscuring the need to make a formal referral. Social workers in such a position need to be very clear about the nature and purpose of discussions, and should always emphasise the requirement for formal referral where there are safeguarding concerns. There is a need to strike an appropriate balance so that any informal discussions assist school staff in making appropriate referrals rather than inhibit them from doing so.

13.6 When Child B was brought to hospital on 17th January there were a number of weaknesses in the way he was dealt with. The history taken regarding causation of the injuries was inadequate, with no recorded family or social background. The review undertaken by a paediatrician was unclear and unsatisfactory. Although the assessment of Child B's neurological status was adequate, the child was not fully examined – there was an over-concentration on his facial injuries, again no adequate history was taken, and there was no entry in the medical notes. There was no clear discharge plan and any advice to his mother was not documented. Most importantly,

the possibility that his injuries might have been inflicted was not given adequate consideration. His disability may have led to a lack of alertness to safeguarding issues.

13.7 There is research evidence that such errors are more common in dealing with disabled children. Causative factors include

- Negative attitudes to disability which create both a vulnerability to abuse and make it less likely that disabled children will be heard.
- A misconception that disabled children are not abused.
- A lack of awareness among carers, professionals and the general
- public of the vulnerability of disabled children and the indicators of
- abuse for disabled children.
- Over- identification with the child's parents/carers.
- Behaviours or injuries that may indicate abuse or neglect being confused with those associated with the child's disability.

13.8 There are some correspondences between the findings of this Review and case reviews previously carried out in Bexley. Agencies will need to re-consider those earlier reviews to ensure that any relevant actions recommended have been followed up appropriately.

13.9 The Review received evidence of initiatives led by the LSCB following a routine review of arrangements for safeguarding disabled children in 2010-11 and the review of arrangements for the use CAF in early intervention. This work led to a number of recommendations to build on and improve arrangements for the safeguarding of disabled children in Bexley. Those service improvements will directly address some of the issues arising from this review.

14. RECOMMENDATIONS FROM INDIVIDUAL MANAGEMENT REVIEWS

14.1 Oxleas NHS Foundation Trust

Health Visitors to have a working knowledge of services available to families where there is a disabled child

Audit progress of Family Health Needs Assessment against previous audit 2009/2010 to ensure ongoing assessment of families

Standardization of response in Greenwich and Bexley Community Services of A&E attendance by disabled children under 5

Community Staff to be made aware of escalation process

Review Transfer of Records policy

Supervision to include consideration of use of CAF/TAC approach for children with additional needs

Review the opportunities to implement integrated working between CAMHS and school health services to provide an appropriate school based intervention

14.2 South London Healthcare NHS Trust

Ensure that accident check list is used for all children presenting with injuries to SLHT.

Review appointment system to ensure missed out-patient appointments can be tracked.

Vulnerable children (i.e., all infants and any older child with disabilities) presenting to the Accident & Emergency Department with injuries are fully undressed for examination.

Children under 5 years of age with disabilities presenting to Emergency Departments with injuries will be referred to the Health Visiting Liaison Service for prompt follow up.

Ensure record keeping is of a high standard in line with professional standards.

Disseminate learning from the serious case review to staff, especially ED staff, with emphasis to remind them to remain vigilant to the high risks for children with disabilities.

Review process for referral for specialist equipment and devices for paediatric patients.

14.3 The General Practitioners

Bexley should ensure all GP's understand how they can contribute to the team around the child/CAF process, and appreciate the need for joint working with other agencies so that a comprehensive assessment is made and appropriate support is offered to the child and the family.

14.4 NHS South East London: Health Overview Report

All health agencies to adopt the application of the Common Assessment Framework as the basis for a Team Around the Child approach to children with disabilities

All health professionals to be reminded that they must remain vigilant to the greater risks posed to children with disabilities

14.5 Child B's School

Recommendation 1 Introduction to school and family and knowledge of family and home circumstances Family/School contact

Initial preschool visit to be completed with the child and parents should include key professionals involved in care- including the Community Nurse for children with high medical needs to ensure that there is an holistic view of the child and an early assessment (CAF) is completed or updated. This should include full details of home and family arrangements plus ethnicity and cultural needs

Recommendation 2 Engagement and contact of family with school
The school should increase face to face contact between parents and teachers to improve communication about concerns if they arise including those of attendance and of a safeguarding nature.

Recommendation 3 Attendance
The school should follow up all unexplained absences and take action as necessary. Attendance records to be reviewed and reported to the Headteacher and class teacher at least half termly.

Recommendation 4 Involvement of parents in School Reviews
The school should encourage parents to attend Reviews of the Special Educational Needs Statement. They should receive a letter setting out the details of the review and the importance of their involvement. The reviews should be used to update any information included in an early assessment (CAF) and Team around the Child (TAC) plan.

Recommendation 5 Medical Reviews
If the school has concerns about the medical needs of a child they should seek the consent of the parent to request copies of any relevant medical reports.

Recommendation 6 Action on the facial marks seen on 14 December 2010

6.1 The school must ensure that the Designated Teacher for Safeguarding has sufficient time and resources allocated to the role to enable them to undertake a thorough assessment of risk and actions without delay and keep full and detailed records.

6.2 The school should keep a written and dated chronological record of every contact regarding a child in need including contact with parents and other professionals. This should be signed and the information should be reviewed to inform decision making if there are safeguarding concerns.

6.3 All discussions with Children Social Care including the Disabled Children Service about the welfare of a child should be recorded by the school with a clear record of any

agreed actions in line with the LSCB Continuum of Need Matrix guidance on application of thresholds for either a referral to Children Social Care or an early assessment of need (CAF).

Recommendation 7 Training Needs
The following Training Needs were identified for schools in this Review and training is recommended to address:

- Making a safeguarding referral- what happens next
- Making a referral to Children's Social Care - completing forms and communication and timeliness
- Common Assessment Framework - Who, When, How and Why
- Safeguarding indicators
- Understanding and identifying indicators of possible accidental vs non accidental injuries (particularly for Heads of Special Schools
- Dealing with difficult or uncomfortable subjects with parents
- Relevance of social context of children to their protection

14.6 Bexley Children's Social Care Services

Where a case is not open/allocated Social Workers should be advised to direct agencies who have concerns about children to discuss their concerns with the relevant duty social worker or with the safeguarding children service for a consultation, that consultation must be recorded on the child's electronic record.

14.7 Greenwich Children's Services

No recommendations

14.8 Metropolitan Police Service

No recommendations

15. RECOMMENDATIONS FROM THIS OVERVIEW REPORT

15.1 Introduction

15.1.1 These recommendations arise from this Overview Report which reflects the views of the SCR Panel and the independent Overview Report author. They may overlap with the recommendations, set out above, made by individual agencies. They are in line with the Government's guidance[21] that Serious Case Reviews should *"focus on a small number of key areas with specific and achievable proposals for change".*

15.1.2 These recommendations are all important but the Panel took the view that none of them required immediate implementation.

15.2 Recommendations to the Bexley Safeguarding Children Board

15.2.2 The Board should, by dissemination of the lessons learned from this Review, remind staff in all agencies of

1) the requirement to refer all concerns about safeguarding to Children's Social Care
2) the vulnerability to abuse of children with disabilities
3) the need to ensure that concerns about abuse of children with disabilities are recognised as such and followed up appropriately

15.2.3 The Board should evaluate agencies' awareness of lessons learned from previous reviews and take action as appropriate.

15.3 Recommendations to the London Borough of Bexley

15.3.1 The local authority should review its arrangements for drawing up Statements of Special Educational Needs to ensure that they include a full family history which is then passed to the relevant school.

15.3.2 The local authority should review its arrangements for transporting very young children with special educational needs to/from school take into consideration the experience of the child.

15.3.3 The local authority should, by dissemination of the lessons learned from this Review, remind all schools of the need to keep accurate records of children's home circumstances.

15.4 Recommendation to all agencies

15.4.1 All agencies[22] should work together to establish and implement clear guidelines on early assessment and information sharing arrangements, with particular reference to children with disabilities and complex health needs.

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[21] "Working Together" (2010)
[22] This recommendation is not relevant to the Metropolitan Police Service but is otherwise addressed to all agencies involved in this Review

APPENDIX A: TERMS OF REFERENCE

Serious Case Review on Child B

The following Terms of Reference have been agreed at the Initial Serious Case Review Panel held on 16 February 2011. These terms of reference are based on the guidance provided in Working Together 2010 (8.20). These terms of reference may be adapted or revised as issues come to light during the course of the review.

Decision to hold SCR

This case was referred to the LSCB on 24 January 2011 and following the Rapid Response under the Child Death Overview process was considered by the Standing Serious Case Review Panel on 2 February 2011.

On 9 February 2011 the LSCB Independent Chairman, Brian Boxall, agreed to hold a Serious Case Review and notifications were sent to Ofsted and Department for Education on that date.

The decision to undertake a SCR was made based on Working Together 8.9
When a child dies ***and*** *abuse or neglect is known or suspected*
to be a factor in the death

"Given the number of injuries, the conflicting explanation for how some of the injuries occurred, the issue of potential neglect due to the 16 year old being in charge of the child, I believe that the criteria for undertaking a review have been fulfilled as set out in 8.9 of Working Together"

Governance Arrangements for the Serious Case Review

Bexley LSCB has a standing Serious Case Review (SCR) Panel with senior membership from the LSCB Partner Agencies. The Panel for this SCR is made up of a core membership of the Standing SCR Panel with additional membership relating to the specific issues in this case.

The SCR Panel is independently chaired by Rory Patterson, Deputy Director for Specialist Children's Services, LB Southwark.

Greenwich LSCB has been invited to participate in this SCR because the hospital A&E is in their borough and a young person involved is resident in Greenwich.

Panel Membership

Name / Designation	Agency	Independence / Status
Rory Patterson	Chairman	Independent of all agencies
Director	Oxleas NHS Foundation Trust	Agency involvement, independent of direct line management responsibility
Designated Nurse	Bexley Care Trust	Independent, no case involvement

Designated Doctor	Bexley Care Trust	Independent, no case involvement
Divisional Director of Nursing	South London Healthcare Trust	Agency involvement, independent of direct line management responsibility for case
Deputy Director, Children Social Care & SEN,	LB Bexley Chairman of Standing SCR Panel	Agency involvement, independent of direct line management responsibility for case
Head Teacher	A Bexley school	Independent, no case involvement
Partnership Officer	Bexley Voluntary Services Council	Independent, no case involvement
Deputy Director, Youth & Inclusion	LB Bexley	Independent, no case involvement
Detective Chief Inspector	Bexley Borough Police	Independent, no case involvement
Children's Safeguarding Manager	Royal Borough of Greenwich, representing Greenwich LSCB	Independent, Greenwich agency involvement

In attendance

Kevin Harrington	Overview Author	Independent of all agencies
LSCB Manager	LB Bexley	No case involvement
LSCB Business Officer	LB Bexley	No case involvement

In addition to the SCR Panel 3 IMR Authors Groups will be held

All Reports will be anonymised before submission using:

Child B – Subject
Child C – Sibling
Ms D - Mother
Mr E - Father
Young Person F

The Panel is deemed to be quorate if the Chair and at least 4 agencies are represented, including health and social care services.

The Panel will provide independence and challenge. It will recommend the Overview report to the LSCB for sign off.

Commissioning of an Independent Overview Report Writer

Kevin Harrington has been appointed as the Independent Overview Report Writer. He is fully independent of all agencies involved in this SCR.

The Overview report will follow the guidelines set out in Working Together 2010 (8.40). It will be published in full with any necessary redaction to ensure confidentiality of the

surviving child and family members. An Executive Summary will be produced by the Overview Report Writer.

The Overview Writer will liaise through the LSCB Manager.

Once agreed by the SCR Panel the Overview Report will be presented to the LSCB and signed off by the LSCB Chairman on behalf of all LSCB members.

Background to Case

This SCR involves Child B (aged 3 years). Child B lived with his mother, Ms D, and his older sibling, Child C. His parents were estranged but he had regular contact with his father, Mr E. His mother had recently formed a relationship with a young person, YPF.

Child B had Dravet's Syndrome, also called severe myoclonic epilepsy, a severe form of epilepsy. From his medical notes it would appear that he suffered from multiple fits, and when falling did not use his arms and hands to break falls.

In January 2011 Child B was taken, by ambulance, to Darent Valley Hospital, he was dead on arrival. The preliminary post mortem was unable to give a cause of death and a second opinion has been ordered. It did identify multiple injuries including bruising and a fracture to the leg.

Child B was unknown to Children's Social Care although he had been referred in the week prior to his death. He was known to universal services, 2 hospitals due to disability had a Statement of Special Educational Needs and attended a Special School Nursery. On 17 January 2011 he had been taken by ambulance to Hospital 2 with facial bruising, mother explained as resulting from a fall from the sofa as a consequence of fitting.

Key Issues

The Bexley LSCB IMR Framework provides the appropriate headings of general issues to be covered in all SCRs based on the guidance in Working Together 2010 in 8.39. The following issues, specific to this case, must also be addressed in the Individual Management Reviews (IMR) and the Overview Report.

- Child B was seen at school with facial injuries in December 2010. Did the action taken by the agencies and professionals involved meet his assessed needs?

- Was Child B's presentation at an Accident & Emergency Department on 17th January 2011 managed appropriately by the professionals involved taking into account both his health needs around his disability and the need to ensure he was safeguarded?

- What was the impact of Child B's disability on how his family functioned? Were appropriate support services provided to Child B and his family?

- Did agencies appropriately balance their responsibilities to support the adults caring for Child B with the requirement to protect him and promote his best interests?

- Were there any issues of culture or ethnicity which affected the response of Child B's family to his disability?

- Was Child B able to express his wishes and feelings? How was communication with Child B managed by those working with him?

- Are there any similarities between the key issues in this case and those which have arisen in any previous reviews (including internal reviews and "near misses") to which the agencies in this case have contributed? If so, can the agencies demonstrate that they had learned lessons and taken action to address those issues?

Individual Management Reviews

- IMRs will be sought from:
- South London Health Care Trust
- School attended by Child B
- Oxleas NHS Foundation Trust
- Bexley Care Trust (GP & Commissioning)
- Bexley Children's Social Care
- Metropolitan Police Service

All IMRs (except police) must be produced in line with the Bexley LSCB IMR Framework. The IMR authors will attend a briefing on the format for the reports and how information should be sought and analysed. There will be an emphasis on how aspects of Child B's care was managed and why any concerns about poor practice came about. Relevant staff in the agencies involved in this SCR should be interviewed and case records read.

Additional reports have been requested to provide background information from other agencies as necessary, this will include:

- Hospital 1 outlining the events when Child B presented at the hospital on the day he died
- Bexley SEN service
- London Ambulance Service

Arrangements will be made through each agency for staff involved in the SCR to receive feedback at key points and for the findings of the IMR to be shared. The full Overview Report once signed off by the LSCB should be shared with the relevant staff prior to any publication.

Time period over which events should be reviewed

The SCR will cover the period since the birth of Child B in March 2007 until his death on 21 January 2011. Any relevant historical information about any of the adults in this family should be included in agency chronologies to ensure the historical context is understood.

Expert Opinion

At this time there is no indication that expert opinion will be required to support this SCR however this will be reviewed at each stage of the review. Additional clarification about the

nature of Child B's disability will in the first instance be sought from Guys & St Thomas' NHS Foundation Trust.

Involvement of Family Members

Whilst the SCR Panel would wish to ensure full involvement of family members in the Review there is an ongoing criminal investigation into the death of Child B that may affect the involvement of family members suspected of involvement in the death and those who are potential witnesses.

The LSCB Manager will liaise with the police Investigating Officer to ensure any involvement of the family does not compromise the criminal investigation. It would be hoped that there will be agreement for the mother and father to be given the opportunity to contribute to the Review through a set of agreed questions as a minimum. The contact with the family members will be made by the Overview Writer and nominated member of the SCR Panel.

The parents of Child B will be informed of the SCR in writing and asked to contribute dependent on the constraints outlined above. The parents will also be asked if there are any members of their extended family that they would wish to contribute to SCR.

They will be informed of the outcome of the SCR by the nominated member of the SCR Panel and will be given the opportunity to comment on the findings, this is again dependent of the constraints/outcome of the criminal investigation.

The parents will be offered bereavement support through the family Health Visitor as is the normal practice of Child Death Overview Panel. Both parents have been allocated a Family Liaison Officer through the Police. Bereavement support for Child C is available through CRUSE if this is assessed as appropriate.

Other parallel reviews

South London Healthcare Trust (SLHT) have initiated a Serious Incident Review. The inter-relationship between this and the SCR will be managed by the (SLHT) representative on the SCR Panel in consultation with the LSCB Manager. The 2 reviews will run in tandem to reduce duplication of effort. Any issues of confidentiality and resultant issues about information sharing will be referred to the SCR Panel Chairman for resolution.

Involvement of organisations in other LSCB areas

Young Person F lived in Greenwich. Hospital 2 is sited in LB Greenwich. Greenwich LSCB has therefore been invited to join the SCR Panel

Coroner's Inquiries/Criminal Investigations

There are ongoing Coroner's Inquiries and Criminal Investigations, timescales for completion of these is unknown at this stage.

Liaison with the Coroner's Office is managed by the LSCB Business Officer.

Liaison with the Police investigation team will be managed by the LSCB Business Officer & Manager.

Media Coverage / Enquiries

To date there has been no media interest in this case. Should there be any media enquiries about the SCR these will be managed through the LSCB Communication Strategy with all enquiries channelled through the LB Bexley Press Office.

Legal Advice

There is no indication that independent legal advice is required at this stage, this can be reviewed at any stage of the SCR.

SCR Review Timescales

This case was notified to the LSCB on 24 January 2011.

The decision to undertake the SCR was made on the 9 February 2011 and the SCR process commenced on this date. The SCR will be completed and submitted to Ofsted by 10 August 2011.

A timetable for the stages of the SCR has been drawn up and agreed by the SCR Panel.
Should an issue with the timescales for completing the SCR emerge during the course of the SCR these will be discussed with Ofsted and DfE and agreement sought for any essential extension.

Liaison with Ofsted & DfE

Liaison with Ofsted & DfE will be managed by the Standing SCR Panel Chairman and LSCB Manager.

APPENDIX B: Biographical details of SCR Chair and Overview Report author

Mr Rory Patterson was appointed as Independent Chairman of the SCR Panel. Mr Patterson qualified as a social worker in 1985 and has spent the last 26 years working in variety of different London Boroughs. He has been Deputy Director in Southwark for the past 5 years, and prior to that held Assistant Director roles in two other London authorities for 8 years where he established a strong track record of good performance and service improvement. Mr Patterson is chair of Southwark's Standing Serious Case Review Panel and member of the Safeguarding Children Board.

Mr Kevin Harrington was appointed to produce this Overview Report, with an accompanying Executive Summary. Kevin Harrington trained in social work and social administration at the London School of Economics. He worked in local government for 25 years in a range of social care and general management positions. Since 2003 he has worked as an independent consultant to health and social care agencies in the public, private and voluntary sectors. He has a particular interest in Serious Case Reviews, in respect of both children and vulnerable adults, and has contributed to more than 35 such reviews. Mr Harrington is also involved in professional regulatory work for the General Medical Council and for the Nursing and Midwifery Council. He has served as a magistrate in the criminal courts in East London for 15 years.

APPENDIX C: REFERENCES

Footnotes have been used to indicate specific quotations from or references to research, practice guidance and other documentation. This Overview Report has been generally informed by the following publications

- Working Together to Safeguard Children,(HM Government 2010)
- London Safeguarding Procedures
- The Victoria Climbie Inquiry (Lord Laming 2003)
- The Protection of Children in England: A Progress Report (Lord Laming 2009)
- The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2007/08
- Safeguarding London's Children: Review of London Serious Case Reviews First Annual Report (London SCB 2007)
- Joint Area Review, Haringey Children's Services Authority Area Review of services for children and young people, with particular reference to safeguarding (2008)
- Improving safeguarding practice, Study of Serious Case Reviews, 2001-2003 Wendy Rose & Julia Barnes DCSF 2008
- Analysing child deaths and serious injury through abuse and neglect: what can we learn – A biennial analysis of serious case reviews 2003-2005
- Understanding Serious Case Reviews and their Impact - a Biennial Analysis of Serious Case Reviews 2005-07 DCSF 2009
- Safeguarding Children a review of the arrangements in the NHS for safeguarding children (CQC July 2009)
- Child maltreatment in the United Kingdom: A study of the prevalence of child abuse and neglect (Cawson, Wattam, Brooker, Kelly November 2000)
- Review of the involvement and action taken by Health Bodies in relation to the case of Baby P (Care Quality Commission (2009).
- Learning together to safeguard children: developing a multiagency systems approach for case reviews. (SCIE 2009)
- The Munro Review of Child Protection: Final Report (HMSO May 2011)
- The Munro Review of Child Protection: Interim Report (HMSO February 2011)
- Publication of Serious Case Review Overview Reports: Letter from Parliamentary Under Secretary of State for Children and Families 10th June 2010