Devon Safeguarding Children Board

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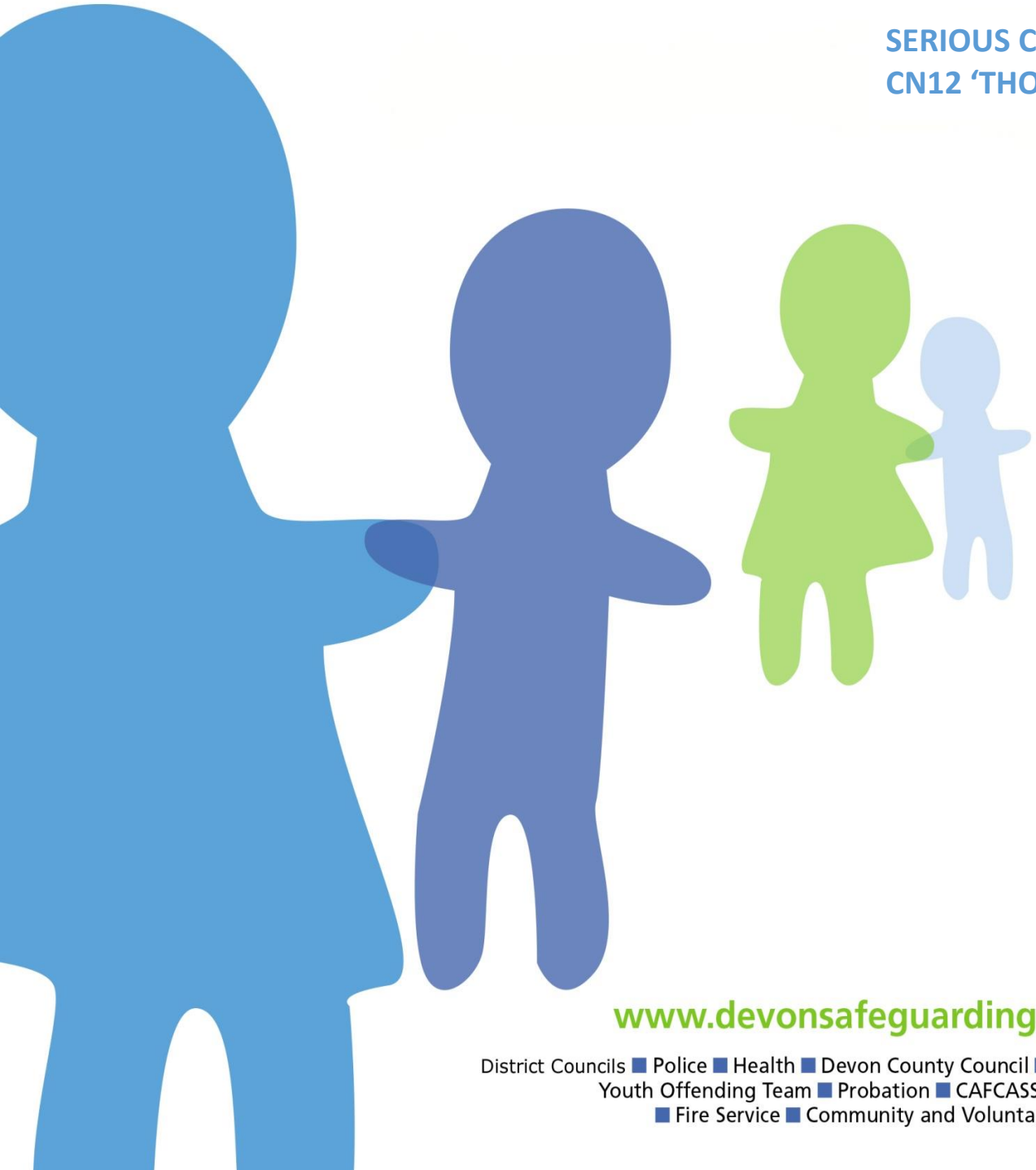
Devon Safeguarding Children Board

SERIOUS CASE REVIEW
CN12 'THOMAS'



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Root Cause Analysis Report

By

palladium patient safety
helping you to keep patients safe

2015

www.palladiumpatientsafety.co.uk

Executive Summary

Background: Following the admission to hospital of a 7 week old infant who was the subject of a Child Protection Plan with a head injury for which no accidental explanation was provided, a serious case review was commissioned in May 2015. The purpose of the review was to explore the effectiveness of the multi-agency working practices in safeguarding this infant and identify systems that would benefit from improvement.

Palladium Patient Safety were commissioned to undertake the serious case review using a Root Cause Analysis methodology. The investigation involves a review of all the available information and evidence with staff from all of the agencies involved with this child and family. The Root Cause Analysis investigation process concentrates on examining system and process failures.

The recommendations are identified in collaboration with the staff from all agencies to reflect a front line perspective of potential solutions. This approach allows those involved to reflect on the incident as a multi-disciplinary team and identify personal and team learning to be shared within their primary area of practice.

Lessons Learned: The multi –agency teams involved in the care of this child recognised the importance of child protection and used the processes detailed in local and national policies. Their self-reflection noted they could have used challenge more effectively. However the opportunity for a holistic view of the situation for these 'at risk' families is not assisted by lack of shared communication processes and opportunity to review cases as a multi-disciplinary team. This is explored in depth in the discussion section of the report

Conclusion: There were opportunities to identify a fuller picture of the whole family risks at the antenatal stage which may have influenced scrutiny of the family behaviours in the post-natal period. It is unclear whether this would have prevented the specific injury – details of which are not fully established

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Background and consequences of the incident

A 7 week old baby, 'Thomas' presented to the local Emergency Department having sustained a serious head injury on the 25th December 2014. The exact time frame and cause of the injuries remain unclear.

There were a number of adults who had care of 'Thomas' whilst at a family party on this date. A Police investigation was completed.

An update of the criminal investigation on the 27th May 2015 confirmed:

> *'The case has not met the criminal threshold so there will be no further action in this respect. There is still a finding of fact to take place and this may reveal further information which requires investigation, however at this stage the criminal case is not proceeding'*

At the time of the injury, 'Thomas' was the subject to a Child Protection Plan. This had been set up pre-birth on the 3rd September 2014. The basis for the Child Protection Plan was the high risk of neglect and the terms of the Child Protection Plan were - 'unborn baby subject to a Child Protection Plan – Neglect'.

Working Together to Safeguard Children[1] describes neglect as:

> *'The persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious impairment of the child's health or development. Neglect may occur during pregnancy as a result of maternal substance abuse. Once a child is born, neglect may involve a parent or carer failing to: provide adequate food, clothing or shelter (including exclusion from home or abandonment); protect a child from physical and emotional harm or danger; ensure adequate supervision (including the use of inadequate care givers); ensure access to appropriate medical care or treatment. It may include neglect of, or unresponsiveness to, a child's basic emotional needs'*

In addition to the Child Protection Plan, a further level of protection had been put into place under the Public Law Outline. This took the form of a 'Schedule of Expectations' which is a written agreement outlining what the parents needed to do or stop doing in order to keep 'Thomas' at home. This was triggered because there were a substantial number of risk factors identified and known by partner agencies for 'Thomas'.

[1] Working Together to Safeguard Children, Department for Education, 2013 www.education.gov.uk/aboutdfe/statutory/g00213160/working-together-to-safeguard-children

The following risk factors for the family had been identified by multi-agency risk assessment[2] leading to the Child Protection Plan:

- The mother had a previous child in 2011 with another partner and this child was removed for adoption in 2014.
- The mother had a history of substance abuse and personal neglect.
- The mother's partner and father of 'Thomas' had a history of violence and petty criminality
- The mother's partner had sustained a brain injury in 2014 as a result of an accident and been assessed as lacking capacity in November 2014.
- The mother's partner had a history of substance abuse and personal neglect.

Following reporting of the injury to 'Thomas' sustained on 25/26th December 2014, the Serious Case review sub group agreed that 'Thomas' had suffered significant harm. In addition there were concerns about the effectiveness of the multiagency arrangements in place to protect him.

Scope of the Serious Case Review

Timescale

The review covers a 16 week period from 3rd September 2014 to 25th December 2014.

This reflects the commencement of the Child Protection Plan for the unborn baby to the date when the serious head injury was identified.

The report author reviewed all information provided by the various agencies either side of these dates and decided to include additional information. In particular, information relating to the past history of the father of 'Thomas' was included in the final scope of the review.

Lines of Enquiry

The terms of reference of the review were agreed at the outset and include questions described in Devon Safeguarding Children Board[2] along with the specific areas of enquiry for 'Thomas'.

[2] South West Child Protection Procedures http://www.online-procedures.co.uk/swChild Protection/

Questions to be addressed in the Serious Case Review

1. Was every service involved in the safeguarding of 'Thomas 'playing their full part?
2. Was the safeguarding service offered to 'Thomas' based on a clear understanding of the needs of the baby?
3. Was the plan to protect the baby effective?
4. Could the injury to 'Thomas' have been prevented?

The agreed purpose of the review is to establish what lessons can be learned about local practice and working together, and to identify some recommendations for change.

The overall aim is to improve inter-agency working and better safeguard and promote the welfare of children.

Process

The Serious Case review sub group elected to undertake an independent review using a systems process. Use of an independent investigation process is supported by many patient safety academics and will 'help to build an open culture that learns from errors and corrects them'[3].

Palladium Patient Safety (report author) were commissioned to conduct the investigation because of their expertise in use of the investigation methodology selected.

The methodology selected is a well-tested investigational approach in healthcare using a toolkit known as 'Root Cause Analysis'.

Use of the Root Cause Analysis toolkit encourages an analytical approach throughout the investigation and will help establish 'what happened, how it happened and why it happened from the perspective of human performance and the performance, or under performance of systems and processes designed to support the delivery of safe and effective care'.[4]

The Root Cause Analysis process used by the report author focusses on a multi-agency approach which encourages team reflection and collaborative working. It promotes the process of sharing learning. By using a multi-agency approach, the teams involved in working with 'Thomas' are given an opportunity to collaboratively identify where local systems and processes may have failed to function in the best interests of 'Thomas'. The Root Cause Analysis approach allows them to actively work together using brain storming/writing and analysis tools to identify improvements to reduce the risk of recurrence.

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[3] Macrae C and Vincent C 'Learning from failure: the need for independent safety investigation in healthcare' Journal of the Royal Society of Medicine; 2014, 107 (11) 439-443

[4] Dineen M 'Six Steps to Root Cause Analysis'; www.consequence.org.uk

Contributions to the Root Cause Analysis process were provided by representatives of the following teams:

- Children's Social Care.
- Health Visiting.
- Midwifery Services.
- Primary Care.

Involvement and support of the parents

Mother and Father of baby have been contacted twice by letter by the Devon Safeguarding Children Board Business Unit to ascertain if they would like to contribute to the Serious Case process. No response has been received from them to date.

Contact and support has been offered and maintained to the family by the local authority and partner agencies.

Agencies who had contact with baby/family

Details of the agencies involved in 'Thomas' and his family include: Children Social Work, Adult Mental Health Services (Devon), Midwifery, Health Visiting, Drug and Alcohol Services – Devon, Devon & Cornwall Police, General Practice and South Western Ambulance Service.

The following agencies confirmed they had no contact with the baby/family:

Torbay Council – Children's Services.

Notable Practice identified by Root Cause Analysis meeting attendees and report author

1. Devon Safeguarding Children Board commissioning an independent review is suggestive of an open and just culture creating an environment where 'causes of serious events can be established and lessons widely learned'[5]
2. The case is being viewed as an opportunity to learn by partner agencies and there is an undertaking from all agencies to share any learning widely.
3. Individual practitioners tried to work to the best interest of 'Thomas'.
4. Concerns about the welfare of the unborn baby were recognised when the pregnancy was declared to maternity services and a Multi-Agency Safeguarding Hub referral was made by Midwifery Services to the local authority in compliance with Working Together 2015.
5. Mother was noted to be caring for 'Thomas' appropriately during the scheduled visits by various agencies and they wished this to be recognised. This was different to behaviour noted with her previous child.

[5] 'Investigating clinical incidents in the NHS', Health Select Committee May 2015

6. All of the attendees at the Root Cause Analysis meeting and the General Practitioner's interviewed have current knowledge of safeguarding responsibilities and processes. They are either up to date with their safeguarding training at the appropriate level; or booked on an update course.
7. The General Practitioner practice evidenced rapid response following flagging of increased risk profile of 'Thomas' at the General Practitioner visit on the 22nd December 2014. Their internal flagging system on patient records was effective.

Mapping and Analysis of the Incident

Source materials

In addition to using a tabular timeline and referencing policies for the agencies involved for the review, other documents referenced were:

- Single agency reports.
- Chronological timeline developed by Devon Safeguarding Children Board.
- General Practitioner meeting summary records.
- Acute hospital attendance records for 'Thomas'
- Root Cause Analysis meeting summary records.

Rationale for use of a timeline

A chronology of events is essential to a robust investigation. There are several methods of displaying the information such as using a narrative chronology, or tabular timeline. With any method selected by an investigation team the timeline must demonstrate:

- Clarity of information
- Sufficient level of detail especially at critical stages in the storyline
- Notable practice
- Missing information and/or gaps in systems and processes

Development of tabular timeline for 'Thomas'

- The original chronological timeline was collated by the Devon Safeguarding Children Board team with contributions from the agencies involved with 'Thomas' and displayed in Excel spreadsheet format
- The timeline was transferred into a tabular timeline format by the report author
- During the Root Cause Analysis meeting the attendees read through the tabular timeline and updated the information displayed referencing their professional records, baby and family records with additional information to ensure the timeline was an accurate reflection of the events leading up to the end date of the investigation

The Root Cause Analysis review meeting attendees and report author used the visual display of the timeline to identify and analyse:

- Gaps in the services
- Opportunities to improve liaison between partner agencies and between the family and partner agencies

Care and Service Systems Failure Analysis

The multi-agency attendees at the Root Cause Analysis review meeting were separated into two groups and asked to analyse the contributory factors to assess which factors could be separated into 'Care systems failures' or 'Service systems failures'. The notable practice factors are documented on page 9.

The review team and report author had the advantage of retrospective insight and acknowledged that factors may not have been so apparent at the time of occurrence.

The report author has added to this list generated by the minutes of the round table discussions during the Root Cause Analysis review meeting. The issues raised and the impact of the care and service systems failures are explored in more depth in the discussion section of the report.

Recommendations to reduce the risk of recurrence are considered in the discussion section of this report on page 16.

1. Care system failures identified by the review meeting attendees

1.1 Risk assessments were delayed, incomplete and not monitored effectively

1.2 The management of parental behaviours was prioritised over Thomas's needs

1.3 Communication between agencies was constrained by location and resources

1.4 The Core Group did not function effectively and not all of the agencies who could have contributed to the assessment of risks were present at the meetings

2. Service system failures

2.1 Alerting Systems, Information Technology and Information Governance do not work together so that it was impossible for all of the agencies to have a clear picture of all of the risks relating to 'Thomas'.

2.2 Staffing related issues impacted on the day to day management of the Child Protection Plan.

2.3 Staffing related issues such as supervision, staffing levels, and managing absence impacted on the day to day management of the Child Protection Plan.

2.4 Multi-agency professional training and education is not sufficiently joined up which reinforces a silo working approach.

Contributory factors analysis

A fundamental part of a Root Cause Analysis investigation is to identify the contributory and causal factors that contributed to the occurrence of the incident, and/or specific events along the incident pathway.

Recommendations for addressing these contributory factors are included in the discussion section of this report on page 16.

3. Summary of the Contributory Factors

3.1 Baby and family factors:

3.1.1 'Thomas' was subject to a Child Protection Plan having been assessed as at risk of neglect.

3.1.2 There was a history of the mother having a previous child adopted due to neglect.

3.1.3 There was a history of both mother and father misusing drugs and alcohol.

3.1.4 Multiple risk factors including a comprehensive history of offending with regards to the father were not known at the time of the Child Protection Plan being put into place, and were not taken into account during further reviews. The net result was that not all of the agencies were aware of potential for harm from the father for 'Thomas'.

3.1.5 The Police were not routinely involved in Core Group meetings so were not able to contribute information current to the family.

3.1.6 The midwifery and health visitor teams noted concerns as the mother was prioritising the father's needs over 'Thomas' after he was born. Although during visits 'Thomas' appeared to being cared for well, the opportunity to gain access to the family residence was managed by the mother so it was not always easy to see the family in normal circumstances.

3.1.7 Several attempts to make unannounced visits to the home in late December failed as the duty social worker could not gain access.

3.1.8 There were delays in following up failure to attend appointments agreed as part of the Schedule of Expectations. The Mother failed to attend many appointments she had agreed to as part of the Schedule of Expectations citing many reasons for this and there were delays by agencies in following up the missed appointments. The drift with apparently little challenge focussed on the needs of the parents over Thomas.

3.2 Communication factors:

3.2.1 The midwife who made the original referral to the MASH did not receive feedback that the referral was received.

3.2.2 The MASH process was reported by the General Practitioner to be 'cumbersome' and difficult to obtain advice when reporting on to the system. This is a critical system for the child protection process.

3.2.3 There are multiple forms of written and electronic communication which are only accessible by the teams using them, which results in a lack of joined up working and duplication.

3.3 Team working and human interaction factors:

3.3.1 Midwives recognised that when a named midwife is not free to attend a Core Group meeting, apologies are sent when in fact a representative should be sent to ensure continuity in communication.

3.3.2 When 'Thomas' was first seen at the General Practitioner surgery he was reviewed by a trainee who was not aware of the family history. A senior opinion was sought regarding the family and the senior General Practitioner noted the parents smelt of alcohol. As Thomas was not registered with the surgery at the time of the appointment, the General Practitioner was not aware that this may have been a cause for concern. This should have been recognised as a concern whether Thomas was registered with that surgery or not as a child should not be in the care of inebriated parents.

3.3.3 During the Root Cause Analysis review meeting, it was recognised that the Independent Reviewing Officer could have challenged the decision not to remove 'Thomas' at birth.

3.3.4 Team factors also included a lack of shared understanding from all agencies involved about risks to 'Thomas 'and follow up plans.

3.4 Education and training factors:

3.4.1 The review meeting attendees felt that there was a gap in skills for the analysis of risk.

3.4.2 The training programmes available for child protection do not consistently use a simulation approach involving all agencies.

3.5 Equipment factors:

3.5.1 The review meeting attendees suggested that there were inherent risks associated with multiple information technology, recording and working systems in use across the services.

3.6 Task factors:

3.6.1 There was a delay in setting up the Initial Child Protection Conference

3.6.2 The review meeting attendees felt that the assessments completed did not appear to reflect the complete picture of the family circumstances for all agencies.

3.6.3 Multiple delays in referring the father to the appropriate adult services due to his reluctance to engage meant that there was never a complete picture of the risk factors associated with him and his failure to engage with services was allowed to drift unchallenged.

3.7 Environment and Location Factors:

3.7.1 The family were awaiting a house move and there were concerns about where they were living. The family were therefore able to use being out of town or lack of buses as a reason for being late or cancelling appointments as they had no reliable transport

3.8 Organisation & Agencies:

3.8.1 The review meeting attendees felt that a protection plan for a new born needs to be in place from 34 weeks gestation not left until the baby is due as was the case for 'Thomas'.

3.8.2 The hospital discharge planning meeting should have been arranged prior to delivery – although this is often difficult to do given the unpredictability of labour. In this situation the Mother had an admission which suggested that she may go into early labour and so the discharge planning meeting process could have been triggered.

3.8.3 The Core Group membership is decided at the Initial Child Protection Conference and this is frequently open to change. The General Practitioner, Police, the relevant Adult Services and Recovery Intervention Service did not attend the Initial Child Protection Conference which was an opportunity for vital risk factors for 'Thomas' to be shared.

3.8.4 There is currently no standardised membership for the Core Group and attendance inconsistent with multi-agency contributions sporadic and information is being missed as was the case with 'Thomas'.

3.8.5 The General Practitioner did not appear to have been invited to the Initial Child Protection Conference and this team felt that this was a missed opportunity.

4. Root cause(s) identified by multi-agency incident review meeting attendees and report author

The aim of a root cause analysis investigation is to identify and confirm agreed root cause(s).

A root cause analysis as defined by Prof Charles Vincent (Imperial College) is

> '*Not just a retrospective search for root causes, but an attempt to look into the future'* [6]

Despite many individuals working to the best interests of 'Thomas', the review meeting attendees felt that the local child protection establishment of a lead professional in a position to have the ongoing full picture and keep the child at the centre of the decision was deficient. The reasons for this may be linked, in part, to changes in the allocated social workers during this period. It is unclear from the discussions who became the lead social

[6] Vincent, Charles. 'Patient Safety'. Page 111; 2006. Elsevier

worker for 'Thomas' after this date. This event also coincided with the Christmas holidays and the Health Visitor also being away on annual leave. Continuity was inevitably adversely affected by these factors. A number of contributory factors for this system failure include systems design, cross agency working and communication.

4.1 The agencies had an incomplete picture of the parental risk factors from the pre-birth assessment, in particular the father due to lack of engagement of adult social services. As a result they failed to respond to escalating risk factors relating to the father.

4.2 Professionals and agencies adopted an over-optimistic approach to the management of the family. The primary factor was that the team wished the parenting of 'Thomas' to be successful following previous family history of adoption. This was compounded by a reassurance by the 'perceived engagement' demonstrated by the family and the observations of 'positive mothering'.

4.3 The legal processes and thresholds were not challenged despite the instinct that the decision to keep the baby with the family at birth was wrong which resulted in the baby remaining with his family.

4.4 The Core Group was ineffective in keeping 'Thomas' at the centre of the decision making.

5. Lessons Learned identified by multi-agency review meeting attendees and report author

5.1 Safeguarding risk assessments need to be proactive, dynamic, and accurate and kept up to date with current risk factors in order to be effective. They are the key tool for recording assessment of the family. They need to reflect clarity of decision making and actions taken and focus on supporting the needs of the child not the adults.

5.2 Oversight of the risk assessment needs to be led by an individual and effective governance beyond the initial risk assessment. As an example, why was the legal decision not to remove the baby at birth, which with hindsight was considered to be a contributory factor, not challenged by the Core Group?

5.3 The Core Group remit and efficient function should reflect a more assertive approach to keep the child and their risks at the centre of the care.

5.4 The professionals lost situational awareness and their decision-making was distorted by over optimism and a failure to employ professional curiosity with regards the mother. As an example, they failed to question the significance of the historical concerns and listen to their 'professional gut feelings' regarding the past history of domestic violence by the father and the deteriorating parental behaviour.

5.5 All agencies involved need to acknowledge and voice concerns, escalate them promptly and appropriately and challenge decisions made on behalf of a child that

are considered incorrect or inappropriate. The Core Group is the opportunity for all agencies to hear and reflect on the impact of these concerns for the child.

6. Discussion

Working Together to Safeguard Children 2015 states that effective safeguarding in every local area should be underpinned by two key principles:

- Safeguarding is everyone's responsibility: for services to be effective each professional and organisation should play their full part; and
- A child centred approach: for services to be effective they should be based on a clear understanding of the needs and views of children.

Following the Root Cause Analysis meeting discussions, review of the timeline, and the evidence available to the reviewers, the report author provides the following answers to the questions posed in this report.

Question 1: Was every service involved in the safeguarding of 'Thomas' playing their full part?

Working Together 2015 (point 16, page 9) states that:

> *'No single professional can have a full picture of a child's needs and circumstances and, if children and families are to receive the right help at the right time, everyone who comes into contact with them has a role to play in identifying concerns, sharing information and taking prompt action'*.

6.1 Core Groups

6.1.1 The Core Group status and use in practice does not reflect the pivotal role in multi-agency support for recognised at risk families and therefore it was not possible for all of the agencies to play their full part in the safeguarding of 'Thomas'.

6.1.2 The title of the meeting implies that it is a core part of the child protection system locally. However during the discussions it was established that Core Groups do not have standard terms of reference, membership or quorum. The Core Group is primarily administered, facilitated and attended by members of the Social Work team. The Core Group does not fulfil its primary function as the core source of information and management of Child Protection Plans for individual children. As a result, the relevance of the meeting is not recognised or prioritised across all the agencies.

6.1.3 Agencies were either not invited to attend Core Group meetings or were unable to attend as it was not seen as a priority or chose not to attend meetings as they did not know the family. Frequently they had to send apologies due to workload. The lack of attendance of key agencies reduces the opportunity to share risk information across health and social care agencies involved in a Child Protection Plan. This was observed in the case of 'Thomas'.

6.1.4 The report author recommends, as a minimum, that the first Core Group meeting attendance should include contributions from all relevant agencies including the appropriate Adult Services, General Practice and Police to provide a good baseline assessment of the key risks.

6.2 Risk Assessment and Safeguarding

6.2.1 There appeared to be an over reliance on the Social Work team to complete the necessary assessments for children with a Child Protection Plan. 'Working Together' clearly states that safeguarding is everyone's responsibility and there is a need for every professional to accept responsibility for identifying and sharing any risk factors to children. In this case there were several opportunities for risks associated with the father to be followed up more vigorously across the agencies.

6.2.2 As an example, it was recognised that the failure to invite the appropriate Adult Services to Core Group meetings resulted in significant information regarding the father being missed.

6.2.3 The discussions during the Root Cause Analysis review meeting suggest that some members of the multi-agency team were not always actively engaged with the safeguarding process. The General Practitioner's acknowledged that 'they have longer term relationships with many families and can provide background and context to a Child Protection meeting'. They expressed a desire to attend meetings in person or virtually but the opinion of the Root Cause Analysis review meeting attendees suggested that, in practice, this a rare occurrence and General Practitioner's regularly did not attend Core Group meetings despite being invited to attend. The General Practitioner's stated that they fully recognised the importance of child protection meetings and would 'try to attend if they saw the family and had information of relevance for the Child Protection review. They were less likely to attend if they had no direct contact with the patient or follow up meetings'. Copy minutes were of the initial Core Group meeting were held on file for the mother.

6.2.4 When the family presented at the surgery in December and 'Thomas' was registered for the first time, he was seen by a General Practitioner trainee who did not know the family. An appropriate secondary review by a senior General Practitioner took place but they also did not know the family, the safeguarding issues nor the fact that 'Thomas' was subject to a Child Protection Plan. As part of the incident review, both reflected that if they had been party to this information features of the assessment during the appointment, for example the fact that the father was noted to be smelling of alcohol, may have influenced

the follow up review of 'Thomas'. If the General Practitioners were encouraged to be actively involved in Core Group meetings every time then the risk of missing this information would be reduced.

6.2.5 Midwifery felt that they made significant attempts to be involved in safeguarding processes but these attempts were not helped by communication systems across health and social care which did not work well together. As a result they often did not know when Core Group meetings were taking place, they did not receive the minutes from the Core Group meetings or they were delayed. So they were not kept up to date with the current progress for a family or changes in risk factors. In this case it would appear that not all of the agencies had up to date information regarding the risks pertaining to this family. The core source of information on Care First lacked information regarding risks of the father and his escalating behaviours.

6.3 Documentation and Systems

6.3.1 There are a variety of paper and electronic records and care systems in use within the region and none of them apparently interface. The net result of this system variation is that red flags and vital information about risks cannot be easily shared. So despite serious attempts to play their full part often agencies were thwarted in their attempt to share information regarding the family. As an example it was disclosed during the Root Cause Analysis meeting that the baby had been returned to the mother who was now resident in a Mother and Baby Unit. Many of the agencies in attendance were unaware of this.

6.3.2 Multiple systems increase the chances of an individual or family more easily navigating their way around a system unmonitored, and by use of disguised co-operation assuring agencies of compliance with agreed plans. The professionals in the Root Cause Analysis review meeting did not consider the family were deliberately manipulative but acknowledged their 'over-optimism' for the mother to do well with this baby may have impacted on certain decisions.

6.3.3 The policies from all of the agencies referenced during the Root Cause Analysis meeting are current and reference the relevant safeguarding requirements. The report author notes some of the policies run to multiple pages. This puts the risk of key information being difficult for staff to access and follow. This is a general observation and there is no indication of any adverse impact on the management of 'Thomas'.

6.4 Appraisal of Family Behaviours

6.4.1 The report author suggests the 'emotional dimension of working with children and families lead to a distortion in the reasoning because of the unconscious impact it has on where attention is focussed and how information is interpreted'.[7] As an example, the excuse of attendance at hospital appointments preventing meeting with Social Workers could not

[7] Munro E LSE. 'The Munro Report of Child Protection: Final Report – A child centred system'. 2011

readily be challenged without confirmatory communication between agencies. The mother consistently failed to make appointments (RISE/SPLITZ) required as part of the Schedule of Expectations.

6.4.2 The agencies were playing their full part but were persuaded by the parental behaviour and distracted by the family chaos. Brandon et al recognise this as a common phenomenon in safeguarding children cases.

> *"Apparent or disguised cooperation from parents often prevented or delayed understanding of the severity of harm to the child and cases drifted. Where parents ...engineered the focus away from allegations of harm, children went unseen and unheard."*[8]

The report author noted documented examples of complete absence of co-operation by parents. This did not appear to be acted upon and the potential additional risk for 'Thomas' recognised.

James Reason in 'Managing the Risks of Organisational Accidents[9] states

> *' The pursuit of safety is not so much about preventing isolated failures, either human or technical, as about making the system as robust as practicable in the face of its human and operational hazards' (1997).*

6.4.3 It is the opinion of the report author that the Child Protection Plan had been put in place due to potential risks of 'Thomas' being subject to 'neglect' based on previous family history. Observation of the mother and 'Thomas' together concentrated on whether she was caring for him and feeding him. This she appeared to be doing when professionals were allowed access. The report author suggests that if the risk factors regarding the recent criminal history for the father had been known when the Child Protection Plan was put in place then it may have taken into account the fact that 'Thomas' was at risk of physical harm. If the Police had attended the Core Group meetings this would have increased the opportunities for information regarding this to be shared.

6.5 Opportunities for Multi Agency Communication

6.5.1 The General Practitioners, Social Workers and Health Visitors present at the Root Cause Analysis meeting observed that changes in health and social care services that had evolved nationally over the past five years regarding service provision may have reduced the

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[8] Brandon M et al. 'Analysing child deaths and serious injury through abuse and neglect: what can we learn? A biennial analysis of serious cases 2003-005'.
Research Brief DCSF RB023 (PDF) London: Department for Education and Skills.

[9] Professor James Reason Managing the Risks of Organisational Accidents. Ashgate Publishing 1997

opportunity for professional communications; for example the Health Visiting service now deliver their service predominantly in Children's Centres reducing the opportunities for formal and informal communication with some other key agencies.

6.5.2 These changes were considered to have reduced the chances of sharing vital information between different agencies. Section 47 of the Children's Act sets out the requirement of all agencies to communicate vital information citing ''a statutory gateway to data sharing'.

6.5.3 Some of the attendees lacked confidence in challenging decisions made in legal meetings. The report author understands work is underway regarding this. It is recommended that a trial of a simulated training programme which includes all of the agencies involved in children's safeguarding could be set up to test issues raised by case studies such as these in a safe environment.

6.6 Insight and Human Factors

6.6.1 All agencies appeared to be working with the best intentions towards the family but were no helped because the communication systems between them did not interact making it virtually impossible to verify what the parents were telling them and to accurately assess the factors in the family life which would have presented an additional risk to 'Thomas' at birth.

6.6.2 Effective use of human factors understanding and theory involves a mix of these elements in order for teams to undertake their key function as effectively as possible and avoid unreasonable expectation of 'human perfection.' This is as relevant to those involved in Safeguarding Children as in other high-risk industries:

Human Factors Checklist

- Recognition of the need for clear communication between all those involved
- Availability and use of well-designed and effective tools to support the core function
- Clear sense of shared purpose for the core function and respect for each team member's role.
- An endorsement of the agreed process to support the core function with no acceptance of 'work-around'
- A flat hierarchy with the ability to challenge decisions.
- An emphasis on constant improvement and shared learning.
- Leadership who set a high standard whilst also provide meaningful support to their teams

Question 2: Was the safeguarding service offered to 'Thomas' based on a clear understanding of the needs of the baby?

6.7 Core Purpose of Child Protection Plans

6.7.1 In the opinion of the report author the Child Protection Plan outlined what should have happened to keep 'Thomas' safe. This was over-ridden by consideration of the needs of the parents. The actions towards the parents were all well-intentioned but did not place 'Thomas' at the centre of the care. Working Together 2015 (point 20, page 9) states that

> *'Effective safeguarding systems are child centred and that failings in safeguarding are too often the result of losing sight of the needs and views of the children within them, or placing the interests of the adult ahead of the needs of the children'.*

The analysis of the professionals at the Root Cause Analysis review meeting was that this was the biggest failing of the safeguarding processes in this case. The professionals agreed they became distracted by the chaotic lifestyle, the behaviours and the varying needs of both parents and inadvertently put these above the needs of 'Thomas'.

6.7.2 The lack of opportunity for the agencies to meet and share information reduced the chances of the team benefiting from shared 'faint signals'. These are described by Ron Westrum[10] as 'symptomatic events, suspected trends, gut feelings and intelligent speculation' concerns about the parents which in turn reduced the resilience of a team.

6.7.3 The pre-birth assessment took too long to complete once on notice of the pregnancy of a second child considering the first baby had been placed for adoption as a result of neglect. The agencies were aware of the pregnancy in April 2014; and yet the Child Protection Plan was not put into place until September 2014.

6.8 Information Gaps

6.8.1 The result of the delay regarding risk assessment was that vital information regarding the father of 'Thomas' was not mapped out or gathered, shared and discussed openly by the multiagency team.

6.8.2 The review group attendees described their professional behaviour as 'over-optimistic' based on an overwhelming desire and empathy for the mother to manage the baby well this time as she had another child adopted in 2013. Several agencies observed the mother had been caring for 'Thomas 'appropriately and they were very confident that things would be better this time. The report author considers the focus was on whether 'Thomas' appeared to be neglected. It was completely appropriate for the Social Worker and Health Visitor to be observing for signs of neglect as an indication that the mother was reverting to her

[10] Hollnagel et al, 'Resilience Engineering – Chapter 5 A typology of Resilience Situations'; page 55; 2006.

previous behaviour. She did appear to be looking after 'Thomas' well. The desire to support the mother so she could make a success of her parenting is understandable. It was recognised that this may have blurred the more critical analysis of the family situation and overridden suspected underlying risk factors. Professor Eileen Munro confirms that this is a risk for the social worker who cannot help but become deeply involved with a family.[11]

6.8.3 There was little consideration given to the behaviour of the father in the weeks prior to the injury. He had been arrested by the Police only weeks before and this factor did not trigger a review of the family situation and reassessment of the risk factors for 'Thomas'. If the risk factors for the father had been more openly discussed by the agencies involved in the Child Protection Plan the report author suggests that this desire to support the mother may have been interpreted differently.

6.8.4 The supportive approach was further compounded by the fact that some practitioners lacked significant historical information and knowledge regarding the parents including the 'toxic trio' of substance abuse, alcohol overuse and domestic violence and a history of petty crime. There was not a widely shared knowledge regarding father's history and risk factors and therefore it was not possible for an accurate assessment of the risks he presented based on partial information. Significant factors such as when the family did not attend appointments and were not at home for scheduled visits should have been communicated across all the agencies involved and should have triggered a more robust response.

6.8.5 The failure of children's services to engage with adult services in order to find out more about the father's background and current situation was recognised as significant.

6.8.6 Observations were made regarding the mother's focus on the care of the father and caused concern for many of the agencies but not acted upon. As an example, the mother making tea for the father a few hours following delivery of 'Thomas'. This behaviour triggered the midwives to discuss this with the social workers as they felt it was inappropriate. It was considered to be of concern but it was never enough to trigger a more robust response to the management of the Child Protection Plan as the planned visits by any agency had failed to gain access to the family by mid-December.

6.9 Enforcement of the Schedule of Expectations

6.9.1 The mother agreed to engage with various agencies such as RISE/SPLITZ as part of the Schedule of Expectations. Her lack of compliance with elements of the Schedule of Expectations was documented on several occasions and discussed at supervision sessions with the Social Work team but never acted upon. It is not clear what the difference ensuring she attended her appointments would have made on the outcome for 'Thomas' but it is an

[11] HM Government Department of Education. The Munro Review of Child Protection: Final Report – A Child Centred System. 2011 Professor Eileen Munro LSE

example of the way the behaviours of the parents were allowed to drift by the agencies managing the Child Protection Plan.

RISE offers a wide range of services that 'takes an abstinence-based recovery-focused approach for people with high-risk lifestyles'[12] Information from the shared care single agency reports suggests that she was asked to attend RISE for hair strand testing to establish whether she was still using cannabis. Her non-compliance with this requirement of her Schedule of Expectations appears not to have been enforced. Her non-attendance at a RISE meeting was flagged to her verbally on many occasions by several of the agencies including the Family Support Team but not acted upon. The focus was how the mother felt about attending or not attending RISE and not what would happen to 'Thomas' if she didn't comply with the monitoring service offered by them.

The attendees at the Root Cause Analysis review meeting concluded that allowing the compliance with requirements of the Schedule of Expectations to drift did not meet a required safeguarding standard. The subsequent failure to further risk assess this non-compliance resulted in a failure to keep 'Thomas' at the centre of the assessment and should have been recognised as a 'flag' for increased risk. However the report author accepts that this form of support is offered on a voluntary basis and leaves the agencies in a difficult position. The social work team and Family Support Worker made frequent attempts to encourage the mother to keep to the conditions of the Schedule of Expectations but she failed to comply

Question 3: Was the plan to protect the baby effective?

6.10 Baseline Assessment

6.10.1 The attendees at the Root Cause Analysis review meeting felt that initially an appropriate Child Protection Plan had been put in place on the 3rd September 2014, and communicated with relevant agencies; and that it summarised the initial needs and risks to 'Thomas'.

6.10.2 The pre-birth assessment was not completed in a timely manner for the circumstances. The midwifery team had completed a MASH referral in April 2014. There was no further action regarding the child protection for 'Thomas' until June; and the Child Protection Plan was not put in place until September 2014. Vital time to collect and share information regarding the increasing parental risk factors was lost.

6.10.2 There were regular Core Group meetings to monitor the plan and discuss the family. However the Core Group meetings were not attended by all of the relevant agencies. This

[12] Social Care and Health; https://new.devon.gov.uk/adultsocialcareandhealth/health-and-wellbeing/alcohol-and-drug-misuse/

significantly contributed to a lack of information about the father relevant to the Child Protection Plan for 'Thomas'. There was a lot of local knowledge regarding the reasons for and circumstances of a previous child who had been adopted.

6.11 Response to Further Information

6.11.1 It was noted that further assessments should have been prompted by changing risk factors for the baby linked to the demonstration by the father of some more risky behaviours such as the disturbance in October 2014 which involved him being arrested and charged.

6.11.2 Information was missing from the Child Protection Plan for 'Thomas'. The impact of organisation risks associated with Information Governance was noted by all the agencies. At the Root Cause Analysis review meeting the attendees expressed a desire to share local documentation about the individual parents. However there was a perception that the Information Governance requirements of their originating organisations would override the ability to share information. The restrictions, if correct, significantly reduce the opportunity for information sharing; but could be mitigated if all agencies attended the Core Group meetings.

6.11.3 The report author suggests there is too great an emphasis on the Social Worker to arrange and administer the Core Group meetings and subsequently implement all of the elements of the Child Protection Plan. There was a passive approach from other agencies to the purpose of the Core Group. Although other agencies did engage with the plan in this case but it would appear that there is a strong reliance on individual practitioners' professionalism and tenacity and not a consistent approach across the agencies. Currently it is possible to 'opt into' Core Group Meetings where an 'opt out' standard is more appropriate.

6.11.4 The Child Protection Plan that was in place was not robust enough to survive the test of a change in team member, sudden loss of a senior social worker and the impact an extended seasonal holiday would have on the Social Work service.

6.11.5 The report authors recognise that the outcome for 'Thomas' suggests that the plan put into place for him was not effective. However, it is difficult to see how any aspects of the plan might have anticipated or prevented the injury to the child in December 2014.

Question 4: Could the injury to 'Thomas' have been prevented?

6.12.1 Despite the setting up of a Child Protection Plan for 'Thomas' before his birth within the first 6 months of his life he sustained a serious injury requiring hospital admission and specialist assessment.

6.12.2 The report author considers that the specific mode of injury – details of which remain unclear - could not have been prevented unless the child was living away from his family at the time of injury.

7. Overall Recommendations for Devon Safeguarding Children Board

This review provides valuable learning for all the agencies involved as it largely reiterates best practice principles.

The seven specific recommendations were identified by the multi-agency team who had responsibility for 'Thomas' and the report author.

The report author recommends that serious consideration should be given to their implementation as actions in a form that suit the needs of the various teams and services involved in safeguarding children in Devon.

7.1.1 The child should be the focus of the Child Protection process and the needs of the adult should not be considered over those of the child. A series of questions that can be asked during Core Group meetings to prompt this should be developed. As an example 'does this decision truly reflect the safeguarding requirements of this child at this time and does it anticipate future risks?"

7.1.2 Effective review of serious safeguarding incidents needs to be conducted promptly and involve all members of the multi-agency teams referring to all relevant documentation.

7.1.3 The Core Group structure, process and administration should be reviewed. A formal Terms of Reference, core membership and standardised agenda should be established taking into account the contributory risk factors for this investigation. The Core Group needs to be supported by an administrative team to ensure meetings run efficiently and outputs are circulated in a timely manner.

7.1.4 Review of communication systems between agencies both paper and electronic regarding children's safeguarding to reflect 'Working Together' and allow agencies to effectively share information to the benefit of the child assessed to be at risk. 'Read only' access to core documentation should be considered to some users.

7.1.5 Professional agencies involved in safeguarding very young children such as Police, Midwifery, Health Visiting, Social Work and General Practitioners, should be offered training to help them recognise and resist attempts by families to hide the risks for children (and pre birth infants) subject to Child Protection Plans and to help them adopt a confident risk focussed challenge to legal advice. Training events should be based on simulated and realistic

case studies involving all partner agencies to test local safeguarding processes, enhance 'professional curiosity' skills and learn together.

7.1.6 Develop alternative opportunities to improve the communication between General Practitioners, Health Visitors and Social Workers to promote team working between all agencies involved in the safeguarding of children.

7.1.7 Risk assess staffing levels, staff supervision and support systems currently in place to ensure full involvement in child protection processes and in particular, individual and teams ability to escalate issues of professional concern. Staffing levels need to be sufficiently flexible to cope with seasonal variation and demand.

8. Arrangements for sharing learning as agreed with Root Cause Analysis review team

1. Review group attendees to reflect on outcome of Root Cause Analysis process during personal supervision sessions.
2. Review group attendees to share learning widely within local teams.
3. Publication of the Serious Case Review Root Cause Analysis report.

9. Other opportunities for sharing the learning to be considered

1. Devon Safeguarding Children Board to share with board members and appropriate sub-group members.
2. Devon Safeguarding Children Board to ensure all partner agencies receive a copy of the report and are requested to disseminate and brief all staff on the findings of the review and actions.
3. Development of local scenario based simulation training programme using a scenario with similar factors.
4. Lessons learned shared in various media such as team newsletters, emails, case history summaries.
5. Review improvements introduced following Serious Case Review using audit methodology.

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