Serious Case Review In Respect of Child

AI

Born 27th September 2006

Seriously Injured 27th February 2007

Executive Summary

September 2008

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1 Introduction

1.1 Background

1.1.1 AI was born on 27th September 2006 to IJ and HI at the local infirmary. He was full term and the delivery was normal. The family are Somalian and Muslim.

1.1.2 On 11th October 2006 HI was detained under Section 2 of the Mental Health Act. She was diagnosed as suffering an acute episode of puerperal psychosis. HI and AI were admitted to the Peri-natal Mental Health unit. They were discharged from the unit on 11th December 2006 to be followed up in the community by District Care Trust City Mental Health Team.

1.1.3 On the 6th February 2007 a referral was received by Children's Social Care from the Community Mental Health Nurse who had that morning received a telephone call from IJ, AI's father, who had reported that he had seen his wife, HI shaking the baby. During a coincidental follow up health appointment on the same day the GP noted a small bruise below AI's left eye and fresh, recent scratches to his right temple. The GP liased with the Health Visitor and requested that the injuries be seen by a paediatrician. AI was then admitted to the local Royal Infirmary for tests and observations. He was discharged two days later.

1.1.4 Children's Social Care, Health Visitor and Primary Care Services and the City Mental Health Team continued to be involved during the next three weeks.

1.1.5 AI was admitted to the local infirmary on 27th February 2007 aged 5 months. His father reported that he was upstairs when he heard his wife scream that the baby was dead, he found AI unresponsive and called the ambulance.

1.1.6 The Consultant Paediatrician at the infirmary also found him to be unresponsive with irregular breathing and abnormal posture of his arms and legs, typical of significant injury to the brain. AI also had a bruise to his right eye and his right pupil was fixed and dilated, the CT scan showed large subdural haemorrhage. He was transferred the same day to the Paediatric Intensive Care Unit at Leeds General Infirmary. The medical diagnosis was that the injuries were serious and life threatening.

1.1.7 Subsequent reports concluded that a shaking assault seemed the most likely cause of the injury, and it was highly likely that AI would be severely disabled as a result.

1.1.8 The family were not previously known to any of the agencies prior to 17th March 2006 when HI booked in with the midwife. (Except universal services for adults e.g. General Practitioner). AI was not the subject of child protection registration or legal proceedings nor was he "Looked After".

1.1.9 HI was arrested and questioned by the Police. IJ has also been questioned by the Police. The criminal investigation is ongoing.

1.1.10 AI is currently subject to Care Proceedings.

1.2 Contributions

The following agencies were represented on the panel:

- NSPCC (Author of the report)
- Primary Care Trust
- Children's Safeguarding and Reviewing Unit
- West Yorkshire Police
- West Yorkshire Probation
- Mental Health Services
- Children's Social Care

Management reports were received from:

- Bradford Children's Social Care
- Children's Safeguarding and Reviewing Unit
- West Yorkshire Police
- Bradford and Airedale tPCT- Health Visiting Service
- Bradford and Airedale tPCT -General Practitioner
- Bradford District Care Trust
- Bradford Teaching Hospitals Foundation Trust
- Leeds Partnerships NHS Foundation Trust and Leeds Primary Care Trust

Bradford HomeStart also contributed to the chronology

Whilst the chair of the panel has written to AI's parents in order to notify them of the Serious Case Review, it was decided given the on going Criminal and Civil Proceedings that any discussion with them including any face to face meetings would not be appropriate.

2 The Facts

2.1 Family Composition

Father	IJ	Born 1956
Mother	HI	Born 1982*
Subject:	**AI**	**DOB 27.09.2006**

* **Whilst the year is given as 1982 HI has since said that she lied about her age when she came to the U.K. and that her real year of birth is 1988.**

2.2 Brief Family History

2.2.1 IJ came to live in the UK in 2002. IJ did not have a Criminal Record and was previously unknown to Children's Social Care.

2.2.2 In 2004 IJ and HI were married in Somalia. The year after they were married, HI joined her husband in the UK.

2.2.3 Towards the end of 2005 HI conceived her first child (AI) and booked with her midwife about 12 weeks later in March 2006. Prior to this neither HI nor her husband were known to any of the agencies noted within the serious case review except for usual contact with their General Practitioner based at a practice which had additional responsibilities for University students and their families.

2.2.4 Throughout the antenatal care period, IJ was used as the interpreter. Whilst the antenatal period was straightforward there was no opportunity for HI to share any private, person or intimate issues or develop a confidential relationship with her midwife.

2.2.5 Their son, AI was born on 27th September 2006 and was healthy and born full term. During the 3 days, mother and child remained in hospital and the hospital staff noted no concerns and mother responded well to her baby's needs.

2.2.6 HI and her son AI were discharged after three days, on 30th September with community midwifery service arranged.

2.2.7 The midwife visited two days after the discharge on 2nd October and again three days later on the 5th October. It was noted that all was well and there were no concerns. Within five days of the midwife's visit (10th October 2006) IJ expressed concerns about his wife's behaviour and this call triggered the involvement of District Care Trust mental health services.

2.2.8 HI was diagnosed as suffering an acute episode of puerperal psychosis on 11th October 2006. She was detained under Section 2 of the Mental Health Act and she and her baby were admitted to the Perinatal Mental Health unit, Leeds, the same day.

2.2.9 During HI's stay the concerns expressed included:

- Mother's physical aggression
- Risk to child due to illness
- Risk to other patients and their babies
- Handling of her baby
- Her specific psychotic condition including various hallucinations including; that her husband was dead; she was being accused of murder; someone was trying to kill her baby; someone was telling her to kill her baby

2.2.10 Mother and baby were discharged from The Perinatal unit on 11th December 2006 and subsequent follow up care and support was delivered in the community by District Care Trust, City Mental Health Team, PCT Health Visiting Service and some contacts from a local Children's Centre and Homestart.

2.2.11 On the 6th February 2007 IJ, AI's father, reported to the Community Mental Health Nurse that he had seen his wife, HI shaking the baby. This generated a referral to Children's Social Care. AI was also seen that day by the General Practitioner. AI had been unwell for a few days and had been prescribed a course of antibiotics on 1st February 2007. During the follow up appointment on the 6th February the General Practitioner noted a small bruise below his left eye and fresh, recent scratches to his right temple. The General Practitioner liaised with the health visitor and requested that the injuries be seen by a paediatrician. Given AI's young age and the dangers associated with shaking a baby AI was admitted the same day to the local infirmary for tests and observations.

2.2.12 These concerns triggered Children's Social Care to commence a Section 47 enquiry.

2.2.13 Children's Social Care, PCT Health Visitor, Primary Care services and the District Care Trust City Mental Health Team continued to be involved during the following three weeks leading up to the significant injury to AI on 27th February 2007.

3. Key Findings

3.1 The Serious case review panel noted some good practice throughout the case. Where there are lessons to be learned these can be built on the positive practice, including the interagency and collaborative working that exists.

3.2 It is difficult to know whether the injuries to AI could have been prevented. AI continues to be the subject of on-going care proceedings. A finding of fact within these proceedings has concluded, and mother accepted responsibility for the injuries to AI. The criminal investigation has not yet concluded. Although the Overview Panel concluded its considerations prior to the finding of fact being known, it is the opinion of the author that this does not change these key findings.

3.3 There were a number of occasions when the professional practice could have been improved upon; these have been identified throughout the report. Each of these may have made some positive difference but it is a combination of them all that gave the panel cause for concern.

3.4 The first was the absence of an interpreter during the antenatal care. Whilst the health care provided by the antenatal services was good, using baby's father as an interpreter meant that the ability to engage effectively with mother by professionals involved was compromised. Mother was not given any opportunity to share personal, private or intimate information in a safe and confidential manner. This engagement process is a crucial element of good assessments.

3.5 Throughout the case some good use of interpreters was made but on the whole this could have been improved upon.

3.6 The panel identified some excellent multi-agency working at the time of mother's diagnosis of a mental illness and subsequent admission of her and baby to the Peri-natal Mental Health unit.

3.7 It was clear at this time there was a potential risk of harm to AI. The professionals involved considered the risk and an appropriate decision was made to keep him with his mother at the Peri-natal unit where the risk could be managed. This was in accordance with NICE guidelines which suggest wherever possible a baby should not be separated from his/her mother.

3.8 The day to day safety of the baby continued to be assessed by the professionals involved at the Peri-natal unit and the risks identified were managed. Consideration was given to referring the concerns to the Local Authority Children's Social Care, who are required to lead the enquiries where there are concerns about the risk of significant harm to a child. However, despite the nature of the concerns, Children's Social Care were not notified or asked to become involved during the stay at the Peri-natal unit. The absence of a referral to Children's Social Care became even more significant at the planning stages for mother and baby's discharge from the unit in December 2006.

3.9 The discharge process also failed to include the risk assessment which should have been completed as identified in the unit's procedures. This assessment would have included all of the historical information including the concerns outlined in 2.2.9 and should have been shared with all relevant agencies. Whilst most of the information was shared to most of the agencies involved the omissions were significant.

3.10 When Children's Social Care received the referral on 6th February 2007 they were clear that there was a duty for them to make enquiries under Section 47 of the Children Act. Even though they did not have all of the historical information, they acted promptly and a medical examination was arranged. However when the allocated worker went off work, due to sickness, the interagency procedures for the core assessment under Section 47 of the Children Act 1989 (Section 47enquiries) were not followed to completion; including the absence of a strategy discussion with the police and consultation with the Safeguarding Unit.

3.11 During the three weeks that Children's Social Care were involved they did not conclude the Section 47 enquiry. Working Together (2006) highlights the three possible outcomes; the concerns are not substantiated; concerns are substantiated but the child is not judged to be at risk or continuing risk of significant harm; concerns are substantiated and the child is judged to be at risk of significant harm.

3.12 Children's Social Care did however continue to make plans for the case and liaised with other disciplines within the department in order to put effective plans in place for an assessment and some support work.

3.13 There was no case record of any decision making process to defer the case in the absence of the social worker, including a record of decisions made to progress or conclude the Section 47 enquiry or a record that a decision was made to conclude the enquiry under Section 47 and proceed down the Section 17 (child in need) route. Linked with this, is the absence of any decision not to have a Child Protection Case Conference. In the absence of any written evidence of management decision making processes, the panel was unclear whether these decisions were made but not recorded or just not made. The BSCB interagency Child Protection Procedures, in line with Working Together (2006) are clear about these processes that in this case were not followed.

3.14 With respect to the Children's Social Care assessment this did not actually begin although plans in place for a family centre assessment to begin. It would have been useful for the Community Mental Health Nurse and Social Worker to have planned their assessments together in order that the potential safeguarding children implications of mother's psychiatric condition could be properly assessed. The joint assessment would have led to a combined health/medical and social care model of assessment, maximising the expertise of both professionals.

4. Recommendations

4.1 All agencies

4.1.1 When a mother is diagnosed with a psychotic illness and the impact of her condition leads to concerns about the welfare of her child then a referral must be made to Children's Social Care at the point of concern. Children's Social Care should be involved in assessing whether any risks to the child are being managed.

4.1.2 Agencies to review their protocols in relation to working with families where communicating in English is compromised. This will include effective use of interpreters for positive engagement with the family at every opportunity but is particularly relevant with respect to assessments.

4.2 Bradford Children's Safeguarding and Reviewing Unit

4.2.1 The Children's Safeguarding and Reviewing Unit be reminded of the importance of consistently recording the advice that they provide to professionals working with children, who request case consultation.

4.3 Bradford Children's Social Care

4.3.1 The Divisional Service Manager for Care Management to discuss with mental health services to produce a clear referral criteria and process. Children's Social Care to clarify with the Care Trust referral criteria and processes. The Integrated Working Guidance Thresholds of Need and Intervention will inform this process.

4.3.2 All Assessment Teams to be reminded of the requirement that a strategy discussion should occur with the Police and Child Protection Unit when undertaking Section 47 investigations as outlined in the BSCB interagency child protection procedures.

4.3.3 Guidance to be issued to all Assessment Teams regarding the drawing up and revising agreements with parents within the context of Section 47 investigations. Clarity to be provided to staff regarding the contribution of other agencies in this process. Expectations to be set within this that agreements would not be changed without consultation with a more senior manager than the person who made the agreement, consultation with Safeguarding Unit and with key partner agencies involved. This to be raised by the Divisional Services Manager in Care Management with all Principal Care Managers with the expectation that they provide guidance to the Senior Care Managers in assessment teams in each of the area offices.

4.3.4 When a S47 enquiry is identified and started, and there is an indication it is unlikely to be completed by the allocated social worker, the case should be re-allocated immediately.

4.3.5 Section 47 and Core Assessment documentation to be reviewed to ensure that it is compliant with guidance as set out in Working Together and Safeguarding Procedures.

4.3.6 Senior care managers are reminded to consistently record the decisions made throughout the Section 47 process. This should include how the enquiry is concluded with a clear outcome as set out in Working Together 2006.

4.4 Leeds Mental Health Trust/Leeds Primary Care Trust

4.4.1 Staff from Leeds Partnerships NHS Foundation Trust to be reminded about the document "Clinical Risk Management, FACE Risk Profile, Policy and Guidance for Staff" with respect to the need to update a FACE risk assessment on discharge.

4.4.2 When a child protection concern is noted on a FACE risk assessment consideration must be given to refer to Children's Social Care. The decision not to refer to Children's Social Care must be discussed with the child protection lead within the agency or with the Local Authority Safeguarding Unit.

4.4.3 When completing FACE risk assessments, risks that are no longer current should not be deleted: they should always be included albeit as historical risks.

4.4.4 When patients are transferred out of the Leeds Partnerships NHS Foundation Trust, an up to date risk assessment should be carried out as identified in Leeds Trust policy and copies of the most recent FACE risk assessments including historical items should be included with the all relevant discharge papers and sent to all involved in the care planning process.

4.4.5 Staff from Leeds Partnerships NHS Foundation Trust to be reminded that a comprehensive discharge summary should be completed within one month of discharge. The discharge summary should include a summary of significant events, especially ones of high risk and ensure that all historical items remain flagged up.

4.5 Bradford Teaching Hospitals Trust

4.51 A protocol to be produced to ensure that during antenatal care, there will be at least one occasion when the midwife routinely asks questions about domestic abuse using appropriate interpreters where required.

4.6 Bradford District Care Trust

4.6.1 Commissioners and relevant service providers to agree a formalised written pathway of care for women, with perinatal mental health problems which identify the respective roles of all mental health workers.

4.6.2 The Trust should develop procedures and clinical pathways regarding the care of women with perinatal mental health problems, and their babies, in accordance with national guidance, to include:-

- An assessment of the needs of the child in discussion with the Health Visitor and GP and Children's Social Care using the Integrated Working Guidance. Thresholds of Need and Intervention
- Guidance regarding inter-agency communication and information sharing.

4.6.3 All child protection concerns must be referred to Children's Social Care and followed up in writing within 48 hours.

4.6.4 Bradford District Care Trust should do everything reasonably possible to ensure there is access to interpreters at short notice when clinically required and out of hours.

4.7 Bradford & Airedale tPCT

4.7.1 The Acute Trust and Primary Care Trust put in place robust arrangements to ensure health visitors are notified of all expected births by the 28th week of pregnancy.

4.7.2 The Primary Care Trust to remind health visiting staff of the core standards to undertake a primary contact to all babies and their mothers between 10-14 days of birth.

4.7.3 That there are improved systems of communication between health professionals. Health Visitors with responsibilities for specialist services should ensure that there is written as well as verbal information sharing with community based colleagues.

4.7.4 The Bradford and Airedale tPCT and BDCT to explore the need for follow-on daycare services post discharge for mothers and their children who have experienced or are experiencing perinatal mental health problems.

4.8 Bradford Safeguarding Children Board

4.8.1 The current multi-agency training to be reviewed to include protocols and pathways for referring to Children's Social Care. This will include use of the Integrated Working Guidance - Thresholds of Need and Intervention and information about the roles and responsibilities of Children's Social Care staff and partner agencies in cases where a child may be at risk or in need.

4.9 Leeds Safeguarding Children Board

4.9.1 The action plan for Leeds Mental Health Trust/Leeds Primary Care Trust to be reviewed by the Leeds Safeguarding Children Board.