South East London Integrated Care System

Safeguarding Forum

https://selondonccg.nhs.uk/healthcare-professionals/safeguarding/southwark/

March 2023

Child D- Serious Case Review

[Working Together to Safeguard Children]

- A guide to inter-agency working to safeguard and promote the welfare of children

Chapter 4: Improving child protection and safeguarding practice

10. Serious child safeguarding cases are those in which:
    - abuse or neglect of a child is known or suspected **and**
    - the child has died or been seriously harmed

The purpose of reviews, at both local and national level, is to identify improvements to be made to safeguard and promote the welfare of children.

Learning is relevant locally, but it has a wider importance for all practitioners working with children and families

Important to understanding whether there are systemic issues

New arrangements- Child Safeguarding Practice Reviews

Child D- summary and context

- Child D's mother, father and older sibling moved to Southwark in April 2016
  - Registered with final practice Oct 2017, this was their third GP practice since April 2016 having registered in another Southwark practice April to June 2016, and a Lewisham GP practice June 2016-Oct 2017
- Child D born at term February 2019, no antenatal concerns, no social concerns noted, registered with GP two weeks old
- Child D brought for on time 6 weeks baby check and 8w primary imms, mother attended for postnatal check
  - Notes record thorough and robust routine enquiry regarding support at home, domestic violence and maternal mental health. No concern elicited. Centile for weight recorded as both 10th-24th (correct) and 60th (error- appears to be typing error). Action taken according to correct centile.
- Ambulance called April 2019 (8w+4days), by father, baby unresponsive, resuscitation was unsuccessful, pronounced deceased on scene at home
- An initial 'Rapid Review Meeting' on 01.05.19 identified no grounds for suspecting abuse or neglect prior to what appeared to be a 'sudden unexplained death in infancy' (SUDI).
- Subsequent post-mortem examinations revealed a large number of fractured bones in a 'non-mobile' baby.
- A criminal investigation was initiated and both parents were arrested, interviewed under caution on suspicion of grievous bodily harm, and at a later date, murder. Legal proceedings were finally completed in early 2022.
- In parallel with urgent protective responses for child D's older sibling were undertaken

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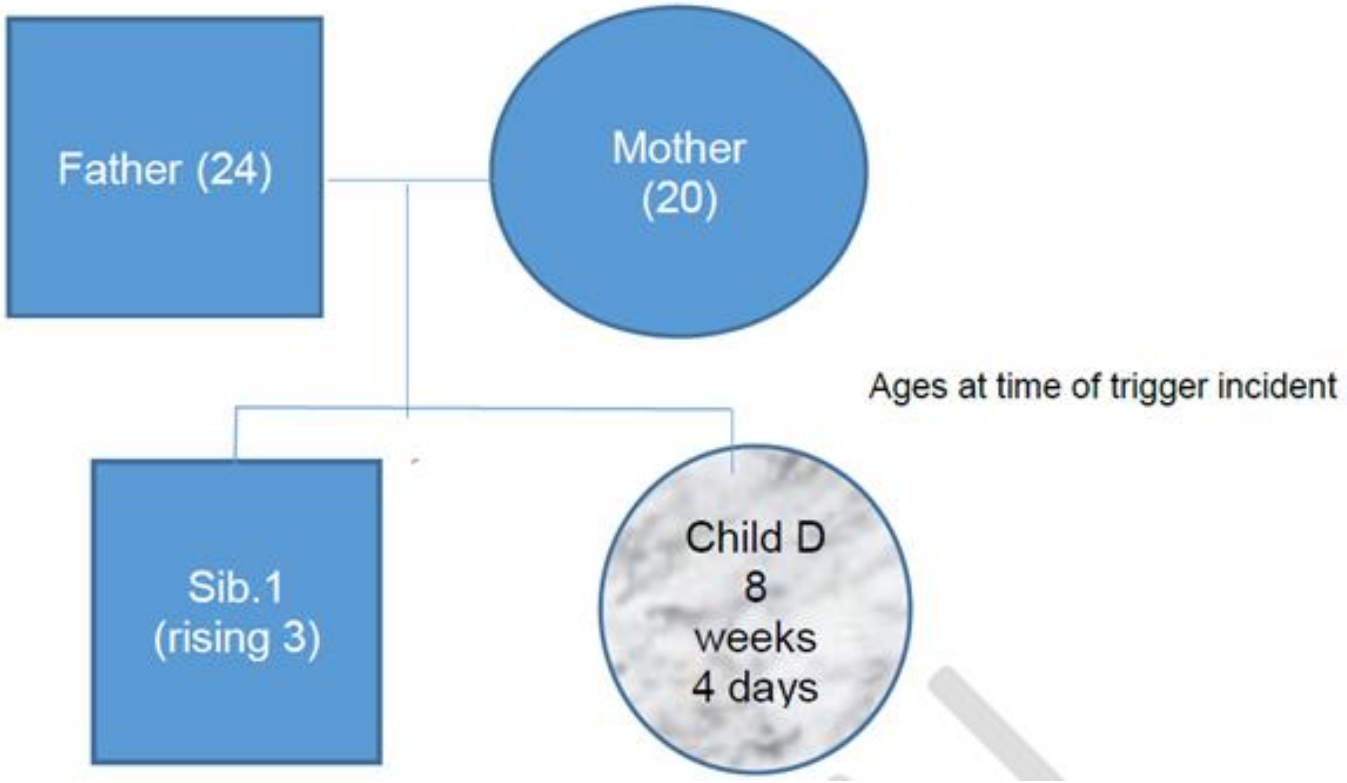
NHS South East London

Genogram- Family Structure



Primary Care- ‘what did we know?’ Child D

- Child D registered 2 weeks after birth, alongside the rest of her immediate family who were already registered at the practice. She was presented for age appropriate examinations and primary health care in reference to immunisations.

- There were no concerns noted verbally or within records as to wider child protection or safeguarding issues of concern for which there is record of multiple routine enquiry. There were concerns about faltering growth for which mother was advised to see HV in 2 weeks to have her weight monitored. In the absence of wider concerns it was would be reasonable practice to give this instruction to a parent directly.

- Mother cancelled neonatal follow –up for jaundice. Practice proactively contacted mother following WNB notification

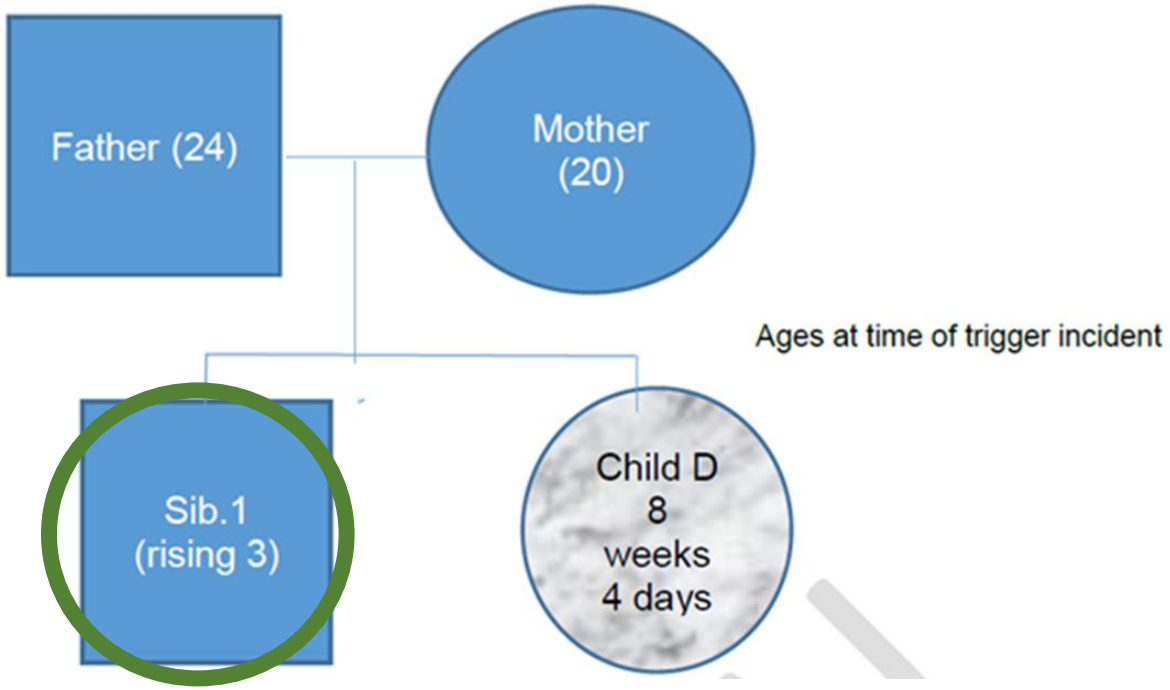
- Under Universal Health Visiting service.

- There is a significant presentation to Out-of-Hour care service, NHS 111, where father was advised to take Child to the ED. Father reported child had vomited fresh blood. The child was not brought as advised.

Primary Care- ‘what did we know?’ Mother and Father

- Mother registered at GP2 in Oct 2017,
  - There is no record of an antenatal referral and she likely self-referred.
  - There were no recorded historic concerns about child protection risk in her records.
- Electronic records extend to 2014
- Mother had been booked in for ante-natal care in early July 2018 when routine enquiries about substance misuse, domestic abuse or mental health difficulties were answered in the negative.
- Ante-natal care of mother continued to be wholly unremarkable and a healthy child D was born by normal delivery
- Mother and Father rarely used GP services, appeared to prefer/need out-of-hours services. They did not however meet definition of ‘frequent’ or ‘repeat’ caller
  - 17 calls over time of review
  - Mostly suitable for primary care
  - Father discussed ‘PTSD’ with NHS111 and HV- no wider evidence for diagnosis
- Sibling- chronic finger nail infection- OOH calls in spring and autumn 2018

‘What didn’t we know?’



Sibling 1 Jan/Feb 2018

Cluster of NHS111 calls by both parents triggered by concerns about their own health.

Two NHS 111 calls regarding sibling 1 Feb 2018, then aged 2yrs

- Sore throat- advised to contact primary care- no record advice was followed
- Second experienced a ‘seizure’ LAS booked, but father later called to cancel stating he had recovered
- Following day presented to ED with a fever, admitted with influenza, on examination circular bruise ? Bite, left deltoid, parents unable to explain.
- Referral to MASH made- delayed in presentations, unexplained bruise
- Case closed to children social care after 3d, further examination concluded mark was not a bite, agency response deemed proportionate
- Hospital discharge sent to previous GP- seen on LCR only during review

Primary Care- ‘what didn’t we know?’ Mother and Father

Mother declined offer of Family Nurse Partnership following birth of sibling 1 in 2016 (mother was aged 20yrs)

Two incidents of police involvement ‘small verbal argument’ Aug 2017 ‘domestic incident’ Jan 2018

- DASH tool assessment graded as ‘standard’
- DASH (Domestic Abuse, Stalking and Honour-based Violence Risk Identification Checklist)
- Merlin not sent to health or children social care.

Father discussed ‘PTSD’ with HV- unclear if encouraged to seek review with GP

Mother described crying as ‘temper tantum’ when in father’s arms in HV visit

Multi-agency learning and themes

GP services

- Evidence of robust and thorough GP and antenatal screening
- Evidence of appropriate professional curiosity on GP following up cancelled appointment about jaundice.
- Need to ensure 'notifications that out of hour services are clinically evaluated alongside scanning to child's medical records'
    - Is there an audit trail in your practice process?
    - Child D not brought to hospital after OOH call from father describing bleeding from the mouth
    - Note - no known concern at the time

Health Visiting

- Universal Service HV consistent with known facts and observations
- Missed opportunities to explore reported 'PTSD' in father and 'temper tantrums' that mother reported happened in father's arms

Opportunities for developing insight into family

- Missed Merlin
- Missed key discharge summary for sibling 1

Emerging Learning

Final review

'Even with the advantage of hindsight, it cannot reasonably be argued that the serious injuries (inflicted by one or both of those with access to child D and concluded by the Judge in Care Proceedings to have been by father, with mother failing to protect) might have been anticipated and steps taken to protect the baby. The criminal investigation and subsequent prosecution have attributed criminal responsibility for child D's death, but little by way of motivation or context.

Evidence generated by the Care Proceedings suggested that both parents were capable of lying and sought to and often succeeded in misleading a range of professionals with whom they had had contact.'

Key Learning and Recommendations

Post-natal review

- Routine enquiry as to mood and domestic abuse

Practice summarisation

- Historic child protection cases flagged to safeguarding lead to ensure information coded in most appropriate way and consider if enquiries needed with previous practice

Record keeping

- Continue to scan child protection information and apply appropriate codes to parents/carers and index children

GP2GP

Antenatal referral

- Self-referrals- lack of notification process currently on risk register. Are you receiving notifications? Are they going to a clinician?
- Updated GST and KCH referral forms contain question on safeguarding concerns