



# **SERIOUS CASE REVIEW Executive summary**

**RELATING TO SARAH  
ETHNIC ORIGIN: WHITE BRITISH**

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## 1.0 INTRODUCTION

1.1 Sarah was a white British child who died aged 4 months in late 2007. She died unexpectedly whilst sleeping on a settee at home. It should be noted that Sarah is not the child's real name, but has been used to anonymise this summary report. She had been swaddled by her father and when he awoke mid-morning he found that the baby was cold. The mother was out and returned to this situation. The emergency services were called but Sarah could not be resuscitated and was pronounced dead at the hospital. The cause of death was not known, but circumstances before and surrounding her death and in particular the discovery during a later examination that she had suffered fractures raised questions about the circumstances of her death. Given these concerns, it was agreed a review of the case should be carried out. Sarah's death was in fact subsequently recorded as a Sudden Infant Death (SIDS) and the injuries were assessed as not related to the cause of death.

1.2 When a child dies and abuse or neglect may be a factor in the death, there is a legal requirement for the Local Safeguarding Children Board, in this case the Nottinghamshire Safeguarding Children Board (NSCB), in accordance with government guidance, to carry out a review of the services delivered by any agencies that had been involved with the family. The NSCB is made up of senior representatives of those agencies concerned with safeguarding and promoting the welfare of children in Nottinghamshire.

The purposes of the review are to:

- establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result; and as a consequence,
- improve inter-agency working and better safeguard and promote the welfare of children.

1.3 In this case the Chair of the NSCB decided that the circumstances surrounding the death of Sarah required that a review should be carried out.

1.4 Each agency that had involvement with the family carried out management reviews and produced reports detailing their involvement and the basis for the decisions made and judgements reached. The aim of these reviews is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about.

1.5 The agencies that carried out management reviews were:

- Connexions
- East Midlands Ambulance Service NHS Trust
- Nottingham Emergency Medical Services [NEMS]
- Nottinghamshire Children and Young Peoples Services
- Nottinghamshire County Teaching PCT [tPCT]
- Nottinghamshire Healthcare NHS Trust
- Nottinghamshire Police
- Nottinghamshire Probation Service
- Nottingham University Hospital Trust [NUH]
- Strategic Housing Services , Borough Council
- Youth Offending Service [YOS]

1.6 The NSCB established a Serious Case Reference Group [SCRG] to oversee the case review process and appointed an Independent author to prepare the Overview Report itself. The Overview Report was written by an experienced professional wholly independent of any of the agencies involved with the case. The author worked closely with SCRG to ensure all lessons were learned through this process.

1.7 The purposes of the Overview process included looking at how and why events occurred, the decisions made and the actions taken or not taken. The professionals involved consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events. The Overview Report summarises what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action.

1.8 This document is a summary of the Overview Report written by the Independent Author.

## **2.0 TERMS OF REFERENCE**

2.1 The terms of reference for the review were agreed by the Serious Case Reference Group and included :

- To establish the facts concerning actions taken by agencies;
- To consider whether NSCB policies and procedures were followed;
- To consider what services were provided in the light of what was known and understood to be necessary;
- To recommend appropriate actions in response to the findings of the review.

2.2 Within these general requirements some issues were specifically required to be considered:

- the quality of the assessment of the parents' abilities in relation to Sarah, in particular:
  - the attachment to Sarah
  - the level of care provided
  - the overall abilities of each parent
  - the impact of drug misuse
  - the impact of mental health problems.
- whether or not assessments were based on all of the available information.
- whether or not multi-agency plans sufficiently reflected the level of need or risk and were effectively executed.
- whether or not multi-agency working was effective.
- whether or not appropriate support services were identified and available.

2.3 After a child dies in these circumstances a multi-agency meeting of staff involved is held to consider the background and any issues that arise for the welfare of surviving children. In this case there was some concern about how that process operated and the review was required to specifically examine:

- the processes adopted after Sarah died, leading up to the multi-agency meeting, including the assessment of the injuries and parental involvement in the arrangements
- how far agency staff felt able to contribute within the meeting and
- the quality of plans arising from the meeting.

### **3.0 FAMILY MEMBER CONTRIBUTIONS**

3.1 In line with Government guidance, both parents were contacted by the Independent author as part of this serious case review. Their comments were taken into account in the conclusions reached by the review

## **4 SUMMARY OF INFORMATION KNOWN TO AGENCIES AND THEIR INVOLVEMENT**

4.1 Prior to Sarah's death, a great deal of information was known to many agencies about the parents and their children. Agencies were regularly involved with the parents for three years after the birth of their first child. The father of the children had a history of mental health difficulties, anxiety and depression and a history of dependency on alcohol and drugs. The children's mother became dependant on drugs after their first child was born.

- 4.2 Both parents attempted to become free of drugs and tried treatment plans and detoxification a number of times. Their drug dependency led to financial difficulties and both parents were known to the police due to offending behaviour.
- 4.3 On a number of occasions agencies were worried about how the parents were coping with the first child and made seven referrals in three years to Children's Social Care under procedures concerned with protecting children from abuse and neglect.
- 4.4 The concerns included:
- When the mother left the family home how the father would manage caring for the child alone.
  - How the child was being looked after by her mother when they were in temporary accommodation.
  - Whether bruising on the child was accidental or not.
  - What the impact of the parents drug use was on the child and how they managed to continue to care for the child when they were under the influence of drugs or alcohol.

At these times it wasn't always clear where the child was and who was caring for her. Generally, however, professionals felt that the parents wanted what was best for their child, were trying and the child was doing well.

Although the child was gaining weight, she was not developing as well as she could have been and extra support was not given to address this.

- 4.5 When Sarah was born specialist staff helped her mother who wanted to be free of drugs but again she found it very difficult to do this.
- 4.6 When Sarah died suddenly, routine investigations arising from the unexpected death of a child were followed. Concerns grew when the injuries to Sarah came to light. Sarah's death was recorded as a Sudden Infant Death (SID) and although the injuries were not seen as connected to the cause of death, they raised concerns and protective action for the surviving child was discussed and taken. Sarah's sibling was subsequently placed with a relative.
- 4.7 The cause of the injuries to Sarah have not been determined. No criminal charges have been brought in relation to this case.

## **5 LESSONS LEARNT**

- 5.1 Although the cause of Sarah's death was recorded as a Sudden Infant Death, there are lessons to be learnt about the way agencies worked together. These particularly surround the recognition of the vulnerability

of both children and the provision of appropriate support services in the light of that vulnerability.

5.2 The lessons to be learnt by agencies working together, from this review are as follows:

5.3 **The status of assessments and their role in decision making, planning intervention and services should always be understood.**

- In this case robust assessment processes in accordance with established procedures were not completed and did not comply with government guidance. They did not involve all relevant professionals nor the family as required. As a consequence the conclusions reached and judgments made were inappropriately reassuring and contradicted known facts.
- The NSCB guidance on assessing the impact of substance misuse was not used to inform the work undertaken.
- Case management decisions were sometimes made without proper consideration of and reference to any assessment or risk analysis having been completed.
- There was no evidence that commissioning assessments by specialists experienced in the areas apparent in this complex case was considered.

5.4 **Threshold criteria for intervention under statutory provisions should be consistently applied.**

- On two occasions legislation and local procedures should have led to the older child being subject to child protection enquiries, which should be commenced when there is a reasonable suspicion that a child has suffered or is likely to suffer significant harm.
- The multiple and complex problems of the family indicated that the child was at least a child in need of services under statutory provisions that require co-ordinated support services to promote her welfare.

5.5 **All plans, interventions and closures should have a clear contingency plan stating the threshold for re-referral and re-assessment.**

- Children's Social Care officers in the Local Authority closed the case file on a number of occasions and ceased involvement with the family. They requested other agencies to monitor the situation without identifying what behaviour, concern or

circumstances would constitute sufficient reason for becoming further involved in the case.

- The identification of what circumstances should generate concern and what should then follow across all agencies could have addressed the repeated disengagement of parents, repeated failures to attend appointments or visits and repeated referrals.

**5.6 Case management decisions by line managers should be evidence based and probe the information available, highlighting gaps and giving direction to the management of a case.**

- There was weakness in the overview exercised by Social Care managers, and the supervision and decision making responsibilities, which if effective should promote a co-ordinated and procedurally appropriate response to a child or young person's circumstances.
- However, the overview of staff by managers within Health appeared robust and knowledgeable.

**5.7 Multi-agency meetings should be managed in a way that ensures that all relevant views and opinions are canvassed and considered before decisions are taken.**

- Some professionals felt unable to voice their concerns during a multi-agency meeting held following Sarah's death and thought that their opinions were not given sufficient weight.
- There was some uncertainty about how it could be ensured that disagreements about the outcome of meetings should be resolved and consideration should be given to revising the procedural arrangements for ensuring this occurs.

**5.8 There was no evidence that the policies and procedures of the NSCB should be fundamentally revised or amended.**

- The difficulties and problems arose for the most part in this case because existing policies and procedures were not consistently adhered to or applied.

**6 RECOMMENDATIONS:**

- 6.1 A range of recommendations, relating to their own organisations, have been made by agencies contributing to this review towards improving the following areas:

- Communication between professionals
- Training and supervision of staff
- Use of existing procedures and documentation
- Coordination of multi-agency working
- Ensuring a child focus by those working with Adults

In addition the following recommendations were made within the Overview report as follows:

#### **In Relation to the Nottinghamshire Safeguarding Children Board**

- 1) The NSCB should audit the use of the multi agency guidance on substance misuse, and promote its use.
- 2) The NSCB should review guidance about safeguarding children when non compliance and disengagement results in discharge from a service by partner agencies.
- 3) The NSCB should further develop guidance / training provided for agencies completing Individual Management Reviews
- 4) All agencies should ensure that staff are aware of how to escalate concerns to senior staff if there is a concern another agency has not complied with multi-agency procedures or guidance.

#### **In Relation to the Children's Social Care Services of the Local Authority**

- 1) CSC should ensure all staff and managers have clear guidance on the thresholds to be applied to determine the status of a referral.
- 2) CSC should ensure all management overview processes are procedurally compliant and adhered to, and that all staff adhere to practice standards when undertaking initial and core assessments.

The NSCB considered the outcome from the review at its meeting in April 2008 and accepted the findings and all of the recommendations. The NSCB will monitor their implementation through action plans to ensure that the lessons learnt from this Review are acted upon appropriately.