SBNI

Safeguarding Board for Northern Ireland

Case Management Review
Executive Summary Report

Alex

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Introduction

The Safeguarding Board for Northern Ireland (SBNI) is an independent statutory body established under the Safeguarding Board Act (Northern Ireland) 2011. The Board became operational in September 2012 and was established by the Department of Health, Social Services and Public Safety (DHSSPS) in recognition of the fact that children are more likely to be protected when agencies work in an all-inclusive, coordinated and consistent way.

The SBNI is made up of key partner organisations from the statutory, community and voluntary sectors, along with lay members who are public appointments. The Board is the key process for agreeing how agencies working with children and families in Northern Ireland will cooperate to safeguard and promote the welfare of children and for ensuring the effectiveness of those agencies. In carrying out our responsibilities, the SBNI will ensure that organisational boundaries between professionals, agencies and sectors do not act as barriers to protecting children and young people up to the age of 18 years.

Section 3(4) of the Safeguarding Board Act (Northern Ireland) 2011 provides for a Case Management Review (CMR) function and the establishment for a CMR Panel to undertake the CMR function on the SBNI's behalf. Section 3(4) of the Safeguarding Board Act (Northern Ireland) 2011 ("the 2011 Act") places a duty on the Safeguarding Board to carry out Case Management Reviews (CMRs) in prescribed circumstances. These circumstances are prescribed under regulation 17 of the Safeguarding Board for Northern Ireland (Membership, Procedure, Function and Committee) Regulations (Northern Ireland) 2012 ("the 2012 Regulations") Section 7(1)(c) of the 2011 Act places a duty on the Safeguarding Board to establish "a committee to be called "the Case Management Review Panel" ("CMR Panel"). In accordance with regulation 38 of the 2012 Regulations, the functions of the CMR Panel include "holding a case management review in such circumstances as are described in regulation 17(2) and (3); and establishing arrangements for sharing the findings of case management reviews." CMRs are undertaken not to find fault with individual practice but rather to examine the organisational systems and processes that assist or allow individuals to make decisions or to act in certain ways in meeting the needs of children and their families, and keeping vulnerable children safe. The focus of the CMR is on learning, that is:

- learning from what has worked well and then build upon it; and

- what has not worked well and determine how this should be prevented in the future.

Other processes co-exist to determine how a child may have died or been seriously injured, or whether individuals need to be held to account for their actions in respect of the child. These issues are not the responsibility of the SBNI.

The DHSSPS have set out clear principles underpinning the CMR process:

- there should be a culture of continuous learning and improvement across the organisations which work together to safeguard and promote the welfare of children – identifying opportunities to draw on what works and promote good practice;

- the process should be conducted with appropriate transparency and sufficient openness to engender professional and public confidence in it;

- the scope of reviews must be proportionate according to the scale and level of complexity of the issues being examined;

- CMRs must be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;

- professionals must be involved fully in reviews and invited to contribute their perspectives without fear of blame for actions they took using their professional judgment and with good intentions;

- families, including surviving children, should be clear about how they are going to be involved in reviews and their expectations should be managed; and

- improvement must be sustained through regular monitoring and follow up so that the findings from these reviews make a real impact on improving outcomes for children.

The SBNI is committed to undertaking CMRs in line with these principles.

REASON FOR COMMISSIONING THE CASE MANAGMENT REVIEW

Alex was found lifeless by the infant's mother in the parents' bed and woke Alex's father who attempted resuscitation of the infant while mother immediately phoned for help. When an ambulance arrived shortly after, the crew took over administering CPR and rushed Alex to hospital where further attempts to revive the infant were unsuccessful. Alex was pronounced dead at the hospital. The hospital emergency department immediately informed the Police Service of Northern Ireland (PSNI) and the Social Work Out of Hours Duty Officer who in turn advised the Trust Chief Executive and Department of Health and Social Services and Public Safety (DHSSPS). The Health and Social Care Board (HSCB) and SBNI were also informed.

The preliminary findings of the post mortem indicated Alex's death was a Sudden Unexplained Death in an Infant (SUDI) and that the death was not suspicious.

After careful consideration, the SBNI determined that this was a case which met the requisite criteria prescribed under regulation 17(2) of the 2012 Regulations for carrying out a CMR. The rationale for referring the matter to the CMR Panel was as follows: –

1. a child had died;

2. the name of the deceased child had been included on the Child Protection Register (CPR) referred to under regulation 17(2)(b)(ii) of the Regulations; and

3. The Safeguarding Board has concerns about the effectiveness in safeguarding and promoting the welfare of children of those persons or bodies represented on the Safeguarding Board by virtue of section 1(2)(b) and (4) of the (Safeguarding Board) Act, particularly due to the family history and the predisposing risk factors present.

A CMR Team was established by SBNI and facilitated by an Independent Chair. The Team comprised of senior representatives of the Trust, Police Service of Northern Ireland (PSNI), the Probation Board for Northern Ireland (PBNI) and a Non-Government Organisation. The terms of reference provided by SBNI included:-

- To review how professionals worked together in assessing and responding to the child's needs since the infant's birth;

- To examine the quality of the assessment of parenting capacity and the parent's ability to follow through on this advice;

- To review the strength of the child protection plan in relation to father's unsupervised access to the child when he was allowed to sleep in the same room/bed as the child;

- To ascertain what advice professionals gave to the parents about co-sleeping; and

- The reasons why there was a lack of toxicology screening of both parents at the time of the child's presentation at hospital.

Individual Agency Reviews were undertaken and provided to the CMR Team by each of the involved agencies. Following a review of these reports, CMR Team members conducted further inquiries, examined case files, and held discussions with a number of identified staff and managers. A review of the integrated chronology demonstrated the high level of inter-disciplinary and interagency liaison and coordination which took place to support this family and to provide safeguards for the young children involved.

The CMR Team acknowledge the cooperation of management and staff within all of the involved agencies and discussions with those directly involved added significantly to their understanding of the complex dynamics of the case.

Prior to the CMR, the Chairperson met with both parents together at the family home to explain the CMR process. On that occasion the parents indicated their total commitment to the process and agreed that CMR Team members could liaise with any of the professionals involved with the family. They asked that the findings be shared with them in due course.

While the terms of reference relate primarily to the ante-natal period and Alex's lifetime, the CMR Team considered that the background information in relation to the earlier parenting of Alex's siblings was relevant to this review and included that in their deliberations.

SUMMARY OF FAMILY HISTORY AND AGENCY INVOLVMENT

Alex's parents grew up in the area in which they were living at the time of Alex's death and had extended family living nearby who offered varying degrees of support. The parents have been together for several years and despite periods of separation, they appeared committed to their relationship and to the children. At the time of Alex's birth they had a number of young children. Alex's father has a long history of drug addiction and criminal behaviour, with many convictions for a variety of offences. He has served a number of prison sentences and identifies prison as when he was introduced to and started misusing drugs.

The family have been known to health visiting services since 2009 and to social services since 2010. They are well known to General Practitioners (GPs) in the local Health Centre. Father has a long history of involvement with PSNI and had been assigned to a specialist unit working with repeat offenders. Similarly he was known to the PBNI over a number of years and they became actively involved with him again in late 2012. Specialist services working with families affected by substance misuse provided by a not for profit organisation were involved in supporting father's sobriety and in helping mother to be a protective parent.

The family were initially referred by the PSNI to the Trust's Gateway Team in Autumn 2010 when mother attempted to supply father with an illegal drug and again several months later when father appeared intoxicated during a drugs search at the family home. Throughout 2011 there were ongoing concerns about drug and alcohol abuse, parental separations and the impact of both parents' mental health on their ability to parent. The case was allocated to a Social Worker in September 2011 and since then there had been intensive involvement by the Trust Social Services Department and the family were in receipt of targeted Health Visiting services. In early 2012 the children's names were added to the Child Protection Register as being potentially at risk of neglect and emotional abuse and when concerns persisted, the potential for care proceedings was formally discussed with the parents in Spring 2012. This resulted in both parents committing to fully engage with the Child Protection Plan.

The children sustained serious injuries in separate accidents within the family home. This included a fractured limb when jumping on a bed and an admission to intensive care. The child was in hospital for a number of weeks and after intensive multi-disciplinary follow-up, has made remarkable progress.

These injuries were thoroughly investigated by police and social services with strong medical input and it was accepted that the injuries were consistent with the explanations, and that the head injury had resulted from an accident which occurred during a short space of time when the child had gained unsupervised access to a spare room where equipment was stored.

When the family was re-housed, a Health Visitor undertook a comprehensive home safety check which resulted in the provision of safety equipment and advice to reduce the risk of home accidents.

When mother became pregnant with Alex, her attendance at ante-natal services was regular and in acknowledgment of the demands of the oldest child's hospital follow up appointments, home visits were conducted by the Community Midwife. Regular advice on preventing Sudden Infant Death or Cot Death was provided throughout the pregnancy and in the post-natal stage by Midwives and the Health Visitor in line with the Healthy Child/Healthy Future Guidelines. This included advice on smoking cessation, placing babies on their back to sleep and co-sleeping.

In acknowledgement of the assessed risks, a pre-birth case conference in late 2012 determined the need to include the unborn child's name on the CPR and to safeguard the infant with a multi-disciplinary child protection plan. An additional requirement that father could not sleep in the family home was added following him being charged with possession of drugs a short time later. The plan was enacted when Alex was born and regularly reviewed by the Core Group of involved professionals and at a further case conference in early 2013.

The short period from Alex's birth until the infant's death as a result of SUDI has been described by all involved professionals as the most stable in the family's history. During the latter part of this period father was cooperating with the extensive conditions of his Probation Order and was engaging well with the specialist service. Both parents were involved with a specialist service, aimed at increasing their understanding of the impact of parental drug misuse. There were no indications that father was abusing drugs, the parental relationship seemed stronger and all the children, including baby Alex, were observed to be well cared for and were meeting their developmental milestones.

THE CHILD'S EXPERIENCE OF DAILY LIFE

The review highlighted that Alex was a much loved and well cared for infant who was meeting developmental milestones. While the mother was the main care giver, father was observed cuddling the infant and participating in both the infant and the siblings' care. The family home was warm and comfortable and the parents had all of the necessary equipment to care for the infant. A full sized cot had been recently delivered but was not yet in use. The child had contact with extended family in the area.

ANALYSIS AND CONCLUSIONS

Alex's death occurred at a time when this family appear to have achieved an increased level of insight and stability and there is no evidence that any additional actions by any of the involved agencies could have prevented this death. The CMR Team particularly commend the individual staff working directly with this family for their commitment and perseverance. Staff in every agency engaged effectively and appropriately with both parents in a manner consistent with their role and were open about sharing their concerns with both parents.

Information sharing between professionals and with parents was excellent and multi-disciplinary attendances at case conferences were generally good. The child protection plan was assessed as having been implemented robustly, and was effective in safeguarding Alex from any intentional harm. However the GPs involved were unable to attend the child protection case conference due to practice commitments and had they been present they could have contributed to the risk analysis and management.

The post mortem report final diagnosis was SUDI – unascertained. The report indicates that Alex was a well-cared for, well-nourished and an otherwise healthy infant with no evidence of accidental or non-accidental injury. It states that there was no evidence of trauma or congenital abnormality. While the exact cause of death could not be established, the autopsy identified that the baby had an infection at the time of death but it was uncertain as to whether this would have definitely proved fatal. The pathologists commented that it was not possible to exclude the possibility that co-sleeping played a part in the fatal sequence.

When a child dies police officers and other professionals must deal sympathetically with grieving parents, even if they need to assess whether a crime has been committed. The law does not allow police officers to insist upon toxicology screening by parents in cases where a child has died unless the police have reasonable grounds to suspect that a crime has been committed. This was not the case in relation to the death of Alex.

Alex was clearly a much loved child and the CMR Team extend their sincere sympathy to the parents, siblings and the wider extended family. The Team also acknowledge that their grief is shared by the professionals who worked closely to support the family and who have also been affected by the death.

KEY LEARNING

Although the cause of death was unascertained there is a well-recognised risk of SUDI associated with co-sleeping in infanthood. The key learning from this case is that professionals in all agencies as well as parents and the general public need to be assisted in having a greater understanding of the risks involved with co-sleeping so that this practice can be even more actively discouraged for the future safety of infants.

The CMR Team was also reminded of the extent of information known to GPs and the importance of the GPs' involvements in risk assessment and case management when there are concerns about parental substance misuse and mental health.

It is also important that case conferences are made aware of all relevant information about parents' and carers' history, including criminal background, to assess its impact on the safety of children.

RECOMMENDATIONS FROM THE REVIEW

Individual agencies made a number of recommendations as to how practice within their own organisations could be further enhanced and have advised the Review Team that these are being implemented.

The CMR Team made a small number of recommendations for consideration by SBNI, including:-

1. Although the cause of death was unascertained there is a well-recognised risk of SUDI associated with co-sleeping in infants. Advice to parents and professionals on the risks of co-sleeping should be revised to take account of the findings of the current SBNI/PHA sponsored research being undertaken in Northern Ireland. Relevant medical, nursing and social care staff in each agency should receive appropriate information and/or training, based on a training needs analysis and a public health education campaign should be considered.

2. Safeguarding Partner Agencies should review existing guidance on sharing information in relation to both children and adults at case conferences to inform the risk assessment and development of a Child Protection Plan.

3. SBNI, HSCB and the Trusts should instigate further debate about creative ways of engaging General Practitioners in the child protection process. While full participation through attendance is still considered to be the most effective way of protecting children other ways of ensuring that General Practitioners' knowledge of families is shared must be considered. This may include greater clarity about the information required from GPs in written reports and considering other opportunities for liaison such as face to face discussions by the Core Group with GPs.

4. SBNI should facilitate a regional debate with key organisations on the circumstances under which parents and carers can be compelled to undertake toxicology screening in the event of a sudden unexplained death in infancy and in particular where co-sleeping has been a factor in the fatal sequence.