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Darlington Safeguarding Partnership
Protecting Children and Adults

SEVEN MINUTE BRIEFING

LEARNING FROM SERIOUS CASE REVIEWS/LESSONS LEARNED REVIEWS CHILD F (JUNE 2019)

This short briefing summarises the findings and lessons from a Serious Case Review (SCR) in undertaken for Child F, who suffered life threatening illness following the ingestion of a Tramadol medication. The SCR focuses specifically on how agencies worked together and individually between June 2014 and April 2018.

A Serious Case Review is required under Local Safeguarding Children Board (LSCB) arrangements, where a child dies or has been seriously harmed in the local authority's area. In this case the DSCB/Darlington Safeguarding Partnership decided that the case reached the threshold for a Serious Case Review and this was endorsed by the Child Safeguarding Practice Review Panel. The purpose of a SCR/LLR is to establish whether any lessons could be learned from how practitioners had worked together to safeguard the child and what recommendations could be made to improve practice. It was agreed that the review would be conducted using the Root Cause Analysis (RCA) methodology which involves uncovering the underlying causes of an incident, where the review panel looks at systems and processes alongside the actions of individuals. It is a systematic & analytical approach to establish what happened, how it happened and why it happened. It is a multi-agency approach to promote, reflection, collaborative working and promote shared learning

CHILD F

Child F was three years of age and lived with his mother and siblings at the time of the incident April 2018. Child F's Mother had 3 previous children removed from her care under the category of neglect. Child F was a Looked After Child between December 2014 and September 2015 when he was placed back into the care of his Mother. In April 2018 Child F was brought to Darlington Memorial Hospital (DMH) following a 999 call from his Mother indicating that his eyes were rolling and that he was sleepy and lethargic following possible ingestion of Tramadol which had been prescribed for her. Mother gave conflicting accounts and was unable to tell medical staff how her child had ingested Tramadol. Child F deteriorated and was transferred to the Great North Children's Hospital at the Royal Victoria Infirmary (RVI), Newcastle upon Tyne. He suffered a respiratory and cardiac arrest whilst in hospital. He was intubated and ventilated, but subsequently, eventually made a full recovery.

A hair strand test indicated that Child F had Tramadol and amphetamines in his system for a period of time and suggested more than one episode of ingestion; this was subject of a police investigation

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THEME 1 – DISGUISED COMPLIANCE

Many of the workers that were involved described Mother as being very cooperative with professionals. She was reported as being willing to undertake any assessments and she worked well with the practitioners when they were present. However, when people who were not involved on a day to day basis such as the Emergency Department staff and ambulance crew saw the family, they described Child F as "unkempt". The forensic psychology report highlighted that there were issues with "social desirability" and "faking good" but practitioners were not alert to this potential. This was because practitioners were unaware of the historical issues (reports had not been shared) and because Mother hid the reality of her situation from practitioners. Her later assertions were that she preferred to manage alone and when she declined early help, confirmed the view that disguised compliance was a factor. **Disguised compliance was felt to be a root cause of the final incident.**

LEARNING:

- **DBC should consider whether there are key reports that are obtained as part of the preparation for court that should be more widely shared when they contain key information to look out for in future.**

THEME 2 – OVER OPTIMISM AND THE IMPORTANCE OF HISTORIC INFORMATION

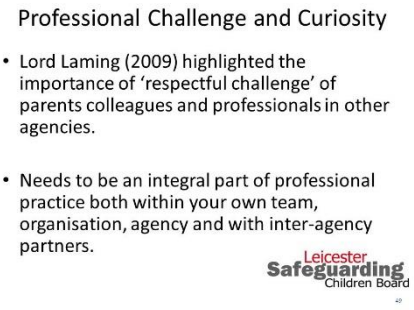
Practitioners describe how they thought that Mother's parenting skills were keeping pace with Child F's needs. There was a belief that she had good family support from her parents and initially from the Foster Mother. Practitioners believed that Mother was being open with them. She shared information openly about her previous children having been removed; she self-reported the bruising on Child F's legs; she appropriately kept Child F away from nursery when he had diarrhoea and she sought appropriate medical help when he needed it. In addition, there were a number of emerging negative signs that were minimised. In particular, the increasing absences from nursery, the worrying Emergency Department (ED) attendance in January 2016 and the increasing attendances at nursery when he was soiled or unkempt. At the Root Cause Analysis meeting attendees described an element of "groupthink" operating. Janis defines groupthink as "a mode of thinking that people engage in when they are deeply cohesive as a group" (Janis 1973). When groupthink is operating, a need for a unified view of reality overrides the ability to look for alternative explanations; in this situation, the factors of Mother self-reporting; family support; Brother 1 returning to the home and Mother having attended all parenting classes were all reinforcing the positive view of her parenting. The author feels

that groupthink led to a lack of professional challenge within the group. **The professionals' over optimism about Mother's abilities is found to be a root cause of the incident.**

LEARNING:

- **Professional curiosity was lacking, particularly in relation to the ED attendance in January 2016 and the increasing nursery absence during 2017 and into early 2018 when Mother started to decline help and support.**

THEME 3 – LACK OF PROFESSIONAL CHALLENGE



Practitioners have been open in describing a number of occasions where there should have been professional challenge. In December 2015 it was stated that the bruising on the legs could have been caused by Mother's explanation of holding Child F tightly to change his nappy. This was not challenged by the practitioners who felt uncomfortable with this explanation. In January 2016 the ED staff were told by social care staff that the case was closed. They could have challenged this and asked for a further assessment or for the case to be reopened. It is not clear whether they recognised the need to challenge and did not feel able to or whether they did not recognise the need for challenge. There was also an opportunity for ED staff to discuss things with the Named Nurse for Safeguarding Children to seek supervision or support, but this did not happen. When a lack of professional challenge was put together with an over optimistic assessment of Mother's parenting ability, in a groupthink situation, this led to the emerging negative findings being ignored and the plan to reduce support to the family continuing without challenge. **The author has found that lack of professional challenge at key points was a contributory factor in the incident.** There was discussion at the RCA meeting as to whether all professionals know when they should be challenging each other. It was felt that for some professionals it was not that they did not want to challenge, it was more a case of not recognising the need for challenge. DSCB/Darlington Safeguarding Partnership (DSP) should explore this concept in training with practitioners.

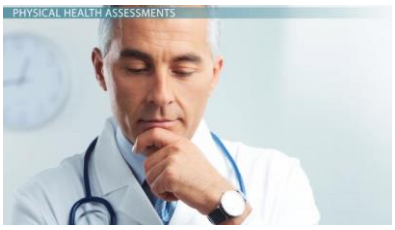
LEARNING:

- **DSCB should ensure that practitioner's understanding pf Professional Challenge is understood in multi-agency and single agency training**
- **DSCB should consider how to strengthen the area of professional challenge. Some suggestions were made in the RCA meeting and whether they can be implemented should be explored by the partnership. The suggestions included:**
    - **Statement to be read out at the beginning of each formal meeting saying that challenge is welcomed**
    - **Possibility of a formal check at the end of every meeting to see whether there has been challenge**
    - ***A* checklist to include has an alternative view been considered**

- **A formal requirement to check for the possibility of disguised compliance**
- **Training for professionals on when and how to challenge and how to receive and act on a challenge**
- **A review of the DSP challenge policy to reflect any change**

- **All agencies should use this case to review whether there is still a hierarchy existing between the professional teams or whether further work to improve inter-professional team working is required.**

THEME 4 – MOTHER'S PHYSICAL HEALTH NOT TAKEN INTO ACCOUNT



During the RCA meeting there was a discussion about Mother's back pain and how she managed to care for Child F with significant pain. Some practitioners were unaware of the pain that she was experiencing or that she was taking strong analgesia. It is difficult to say whether anything would have been done differently had this been explored fully, but the potential danger of a single mother in significant pain, living alone with a very active toddler who may have some developmental delay, should have been explored and the risks minimised. The fact that this was not questioned meant that there was then little realisation that there was a growing danger of prescription medication being available in the house. **The author found that this was a contributory factor in this incident.**

LEARNING:

- **Mother's increasing prescribed dose of Tramadol was not recognised as a concern.**
- **Multi agency training should consider the importance of understanding the use and abuse of prescribed medication. All assessments should consider the use of both prescribed and illicit drugs and practitioners should be familiar with the main prescription medications that could impact on parenting abilities.**

THEME 5 – PRACTITIONERS DID NOT RECOGNISE THE IMPORTANCE OF PRESCRIPTION DRUGS IN THE HOME

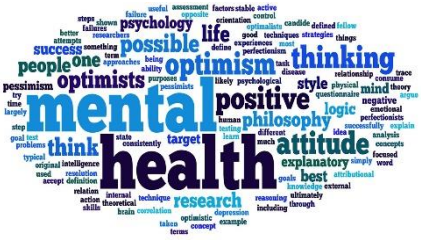
Because Mother's physical health issues were not fully explored by those working with the family, there was no discussion about safe storage of medication. If Child F obtained the medication and ingested it accidentally, this discussion and any following action by Mother may have prevented the accidental ingestion of the Tramadol. Practitioners should ask about the use of prescribed medication during their assessments. Practitioner's lack of awareness of the dangers of prescription medication was also identified as an issue. Practitioners reported feeling reasonably certain that, had they been aware of any illicit drug use in the family, a risk assessment and safeguarding actions would have been taken, but the dangers of Mother taking a high dose of

Tramadol were not recognised. This is a training need for practitioners both in primary care and in social care. The RCA meeting felt that some information on the high-risk, prescribed medications would be useful for practitioners. **The author found that the fact that Tramadol was readily available in the house was a root cause of the incident.**

LEARNING:

- **Practitioners' awareness and knowledge about the dangers of prescription medications was limited.**

THEME 6 – FULL PICTURE OF MOTHER'S MENTAL HEALTH WAS NOT KNOWN



Child F's Mother had a single attendance and assessment within the local mental health provider. This was outside the timescale for the review, but it did show that Mother had Phobic Anxiety Disorder and features of emotionally unstable personality disorder. However, there was no formal diagnosis of a personality disorder. In the RCA meeting it was reported that Maternal Grandmother's Ex-Partner died shortly before the final incident under investigation. He was reported to be a positive influence in Mother's life and this would almost certainly have affected her mood therefore her and parenting abilities. When the issue of Mother's increasing physical pain and recent bereavement are read with the comments in the forensic psychology report about possibility for her to start to misuse substances in the event that she destabilises, it becomes clear that there were a number of serious risks emerging to her parenting abilities. The series of negative findings should have been seen as a warning that things were not going well but as stated above these findings were minimised and the positive culture prevailed. The lack of follow up of the action to randomly test Mother's hair for drugs and the fact that practitioners were unaware of the dangers of prescribed medications meant that a full picture of Mother's mental health was not known. **This is found to be a contributory factor to the incident.**

LEARNING:

- **The lack of follow up of the action to randomly test Mother's hair for drugs and the fact that practitioners were unaware of the dangers of prescribed medications meant that a full picture of Mother's mental health was not known. This is found to be a contributory factor to the incident.**
- **DSP should promote the good information sharing from this review as a learning point but should also review the points in the timeline at which information was not shared and where decisions were made in isolation to explore improvement opportunities.**

THEME 7 – INFORMATION SHARING AND COMMUNICATION

In many Serious Case Reviews there is an element of poor information sharing and communication (HM Gov 2016). In this case, the information about previous child safeguarding proceedings was followed up and practitioners in the 0-19 service quickly shared concerns that led to a rapid paediatric review. These are both positive signs that information was shared between agencies. However, there is also evidence that key pieces of information were not shared. Practitioners were not fully aware of the risks outlined in the forensic psychology report and minutes of the "letter before proceedings" meetings were not shared. DSP should promote the good information sharing from this review as a learning point but should also review the points in the timeline at which information was not shared and where decisions were made in isolation to explore improvement opportunities. **Failing to share or use the historic information from the forensic psychology report is found to be a contributory factor to the incident.**

LEARNING

- **Key information was not shared with front line practitioners, for example the report of Psychiatrist 1 and notes of the Letter Before Proceeding meetings.**
- **DBC should consider whether there are key reports that are obtained as part of the preparation for court that should be more widely shared when they contain key information to look out for in future.**

IDENTIFIED GOOD PRACTICE:

It is important to consider any good practice highlighted in the case. Good practice is defined as that which has had a positive impact and which agencies would like to see consistently undertaken.

Examples in this case include:

- **The Community Midwife contacted social care on at least 2 occasions to ensure that the strategy meeting took place because she knew that all 3 previous deliveries had been early.**
- **Practitioners from all agencies were noted to be actively seeking an early resolution to the question of whether child F would be Looked After immediately after his birth. This was seen as viewing life through the child's eyes and working to best practice.**

- **It was felt that the Early Years Practitioner (EYP) who attempted to follow up after ED attendances was following best practice. She was tenacious in following when these visits were ineffective.**
- **December 2015 the EYP had a conversation with the Mother about bruising to Child F. On the same day this information was passed to social care and the child was brought for a review medical. The timeliness of this information sharing and review was noted at the RCA meeting.**
- **The Nursery reported a number of concerns in relation to Child F's appearance and attendance to children's social care. Even though thresholds were not met they continued to information social care staff of their concerns. This information is important in building up a picture of the deteriorating position within the family.**
- **At the RCA meeting, the Police noted that both the old and the new IT systems are checked within the Darlington Multi-Agency Safeguarding Hub (MASH) for historic information. This does not happen in all areas.**

Sharing Learning from Serious case Reviews/Lessons Learned Reviews is vital in order to improve safeguarding practice.

The engagement with professionals throughout the SCR provided an opportunity to build on the information contained in the agency reports and to understand why actions were taken and decisions made. Having analysed and scrutinised the practice undertaken in this case, it is possible to identify the wider systems learning.

It is important to recognise that practice changes have already been put in place during the timescale of the review. The following recommendations were made, which will continue to improve practice within Darlington:

1. Multi agency training should be provided to explain the importance of understanding the use and abuse of prescribed medication. All assessments should consider the use of both prescribed and illicit drugs and practitioners should be familiar with the main prescription medications that could impact on parenting abilities.
2. Every professional meeting should consider whether previously requested actions were completed by families and by professionals. The completion or otherwise of all actions should be recorded.
3. All agencies should use this case to review whether there is still a hierarchy existing between the professional teams or whether further work to improve inter-professional team working is required.
4. DSCB should consider how to strengthen the area of professional challenge. Some suggestions were made in the RCA meeting and whether they can be implemented should be explored by the partnership. The suggestions included:
    - Statement to be read out at the beginning of each formal meeting saying that challenge is welcomed
    - Possibility of a formal check at the end of every meeting to see whether there has been challenge
    - A checklist to include has an alternative view been considered
    - A formal requirement to check for the possibility of disguised compliance

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- Training for professionals on when and how to challenge and how to receive and act on a challenge
- A review of the DSCB challenge policy to reflect any change

5. At the point of case closure there should be a statement that is clear to all agencies that states under what circumstances the case will be reopened. This should highlight any trigger points that have been identified, such as increasing drug use.
6. DSCB should consider the status of DARP and how professionals' views are fed into the decision-making processes.
7. DSCB should consider the Signs of Safety and if it is the preferred model all agencies must have a consistent understanding of its application.
8. DBC should consider whether there are key reports that are obtained as part of the preparation for court that should be more widely shared when they contain key information to look out for in future.
9. DSCB should consider the points in Child F's life at which decisions were made by single agencies – such as the LBP meeting and consider whether recent changes in process mean that the decision makers have the views of all agencies available to them

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Further information:

If you would like to discuss this briefing or any of its contents, please speak to your line manager or your representative on the DSP. Or contact the Safeguarding Partnership Business Unit on 01325 406450 or by e mail: dsp@darlington.gov.uk

Visit Darlington Safeguarding Partnership website for more information.

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https://learning.nspcc.org.uk/case-reviews/