

Executive Summary of the Overview Report of a Serious Case Review in respect of Child V (female) and other children placed by Rotherham MBC with foster carers Mr. and Mrs. A

1. Circumstances of the Review

This Serious Case Review was commissioned by Rotherham Safeguarding Children Board following the death of Child V in January 2007 whilst in the care of local authority foster carers.

Child V was born in October 2006 and the day after her birth Child V was admitted to Rotherham Special Care Baby Unit (SCBU) showing features of Neonatal Abstinence Syndrome. Her mother was a heroin user.

Child V was accommodated by the local authority on 10 October 2006 and remained in hospital for the first 34 days of her life. She was then discharged to live with Mr. and Mrs. A, Local Authority foster carers and remained with them for the rest of her life.

On 7 January 2007 Child V was taken by ambulance to the Accident and Emergency Department without any heart beat. After extensive resuscitation attempts her heart restarted and she was subsequently transferred to a Children's Hospital Paediatric Intensive Care Unit where she died later that day.

A post mortem examination revealed Child V had suffered an acute heart attack which led to heart and multiple organ failure. There was evidence of gastro enterocolitis (inflammation of the stomach and bowel). There was also evidence that Child V had suffered injuries unconnected to her death. She had a total of 13 rib fractures which were thought to have occurred four weeks before death, with evidence of a recent re-fracture to one rib. The medical evidence suggests that these fractures were sustained as a result of forceful squeezing by an adult.

The post mortem also found healing tears of the upper and lower lip frenuli (sustained one to two weeks before death and consistent with a slap or force feeding) and extensive nappy rash. Child V died with evidence of non-accidental injuries but the cause of death points to a rare cause not related to the non-accidental injuries. As a result of the medical evidence a Police Criminal Investigation was initiated but this has not resulted in any charges being brought.

2. Purpose of the Serious Case Review and Terms of Reference

Serious Case Reviews should always be conducted when a child dies and abuse or neglect is known or suspected to be a factor in the death.

This Review was commissioned in accordance with the Local Safeguarding Children Boards Regulations 2006 and Chapter 8 of "Working Together to Safeguard Children (2006)"

The purpose of this Serious Case Review is to establish what happened, whether information was shared fully by those professionals involved and procedures were appropriately followed, so that any loop holes can be closed and lessons learned to minimise a possible repeat for another child. This should also reassure the public and prevent the need or demand for further external inquiries.

The Safeguarding Children Board agreed the following terms of reference:

1. To review agency involvement and the services offered to Child V from birth until her death.
2. To review agency involvement with Child V's parents during pregnancy and up to her death.
3. To review the recruitment, application, training and approval of the foster carers, and the support and supervision offered to them during their fostering career.
4. To review the placements of all children placed with the foster carers and compliance with fostering regulations.
5. To review the health and wellbeing of all children during their placements and for two months after their placements with the foster carers ended.
6. To review agency involvement with the foster carers' own children from 1 June 2004 until 7 January 2007.
7. To examine inter-agency working and communication between the agencies involved.
8. To consider whether the decisions and actions taken by the agencies involved were in accordance with policies, procedures and relevant practice standards.
9. To make recommendations in respect of any lessons to be drawn from this case and any appropriate action to improve future practices in the light of the review findings.

3. The Independent Author of the Overview Report

Rotherham Safeguarding Children Board commissioned Peter Ward to complete the overview report for this Review. He is independent of all the agencies involved. Mr. Ward has worked in Social Services in practice and in management, has a post-graduate diploma in management studies and undertakes investigations and other consultancy work on an independent basis.

4. Agency Involvement and Reports

The Serious Case Review Panel comprised representatives from:

- Rotherham Metropolitan Borough Council Children and Young People's Services (RMBC CYPS)
- Rotherham District General Hospital – Foundation Trust
- NHS Rotherham
- Rotherham Metropolitan Borough Council Neighbourhoods and Adults Services
- South Yorkshire Police

Also the overview report author and Rotherham's Safeguarding Board Manager were panel members.

The Panel has received and considered Individual Management Reports from:

- Cafcass
- Rotherham District General Hospital – Foundation Trust
- RMBC CYPS Social care
- RMBC CYPS Inclusion, Voice and Influence
- NHS Rotherham
- South Yorkshire Police

Also, a report from RMBC CYPS Early Years Service in respect of an independent pre-school day care provider

5. Family Composition Child V's family

Family Member	Year of Birth	
Child V	2006	Subject (deceased January 2007)
Ms. V - Mother	1981	
Mr. V - Father	1956	
Older Brother (Adopted)	2005	
Paternal half sibling (subject of care)	1996	

order since 2005)
Maternal half sibling (subject of a Residence Order and living with relatives) 1997

Mr. and Mrs. A's family

Family Member	Year of Birth
Mrs. A - Female Foster Carer	1976
Mr. A - Male Foster Carer	1967
Foster Carers' Daughter	1997
Foster Carers' Son	2000

6. Areas considered by the Serious Case Review

6.1 The recruitment, application, training and approval of Mr and Mrs A as foster carers and the support and supervision offered to them during their fostering career

Mr and Mrs A had two children of their own and were assessed as foster carers. The assessment was comprehensive but took too long (16 months) and did not look into the issue of Mr. A working nights and what impact that may have on Mrs. A, who was, in effect, a sole carer. Mrs. A attended all her initial foster carer training but Mr. A did not due to work commitments. There is subsequently no consistent record of training undertaken by the couple.

The couple were accepted as task centred foster carers in June 2005 to care for up to two children or three if a sibling group. Their first placement took place in July 2005 and supervisory visits were appropriately made within the six week minimum standard period. However, later there were longer gaps in supervision visits. A review report in respect of the foster carers was completed and considered by Fostering Panel, albeit that there was no formal review meeting with the carers and a three month delay before the Panel considered the report.

There were four incidents of concern during their time as foster carers:

- 1) In April 2006 a new placement with two siblings broke down after one night as the couple could not cope with the children's needs.
- 2) In June 2006 the mother of a child placed with the couple alleged that the child had been hit by Mrs. A. A full investigation, including a medical examination, was carried out and concluded this was a malicious allegation and no action was taken.

- 3) Foster Child 12 was placed with the couple in July 2006 and was unwell at the time of placement (attributed to a reaction to vaccinations). The couple raised concerns about the child's eating and were advised to monitor him and get medical help if the situation worsened. He was not taken to the doctors over the weekend but during a social work visit on the Monday a social services officer noted that his situation had deteriorated and the child was taken to hospital. He remained in hospital for five days for treatment and concerns were raised that the carers had not picked up the problem earlier. An investigation was carried out and concluded there was no deliberate neglect or inappropriate care.
- 4) In December 2006 a nursery reported concerns about Mrs. A's relationship with Foster Child 7. The Nursery reported that Mrs. A did not make enquiries about Child 7's progress, take the child's work home with her or communicate about absence through illness. There were also concerns raised separately about Child 7 not attending a hospital appointment for a blood test. A joint visit by the child's worker and a fostering supervising social worker to Mrs. A was due to be made in January 2007 but did not take place before the death of Child V. The response to this incident is a matter of concern as the signs that Mrs. A was possibly struggling to cope were not picked up immediately by social care.

Overall the service received by the couple seems to reflect a Fostering Service which was under strain and struggling to meet its statutory obligations.

6.2 Placements with Mr and Mrs A

In total 14 placements were made with the couple, involving 13 children all aged between less than one month and three years of age.

All were within the age range for which the couple were approved (0-4) and all were task centred placements.

However on four occasions a foster child was placed with the couple, above their approved limit. The Fostering Panel was informed of all those placements although after the event.

6.3 Health and wellbeing of children

Nine of the placements with the couple were for four nights or fewer with no medical issues. However, in one instance the couple were not informed of how to care for a child who suffered from epilepsy if he/she had a fit.

Three issues are raised from other placements:

- 1) **Child 12's admission to hospital (see point 3 in section 6) - The**

Foundation Trust staff were concerned by the carers' failure to pick up on this child's illness and correctly informed the relevant partner agency officers. They also were correct to check with Social Care regarding Foster Child 12's mother caring for him on the ward.

- 2) **Faltering Growth** – Four children in the couple's care experienced faltering growth but the significance was neither recognised nor investigated. In addition even if it had, the issue may not have been picked up as a recurring problem as each child's records would have been considered individually.
- 3) **Failure to take children for health appointments** – On five occasions Mrs. A failed to take children in her care for health appointments. In addition the couple did not attend four medical appointments for their own son. This pattern was not picked up as it related to different children and information held by individual agencies and departments was not considered holistically.

6.4 Agency involvement with Mr and Mrs A's own children 2004-2007

Agency involvement with the couple's two children was routine and no concerns have been raised. However, before the period of this review there was a decrease in their daughter's weight. The foster carers also missed some medical appointments with their son. This has additional significance with the benefit of hindsight.

6.5 Agency involvement with Child V's parents

Ms.V had a longstanding history of drug abuse. Mr. and Ms V's first child was born in June 2005 and placed with Mr. and Mrs. A after discharge from hospital until an adoptive placement was found in January 2006.

Ms. V did not seek health care or attend for scans during her pregnancy with Child V but did inform the specialist midwife at a Drug Rehabilitation Unit. The midwife informed Social Care of the pregnancy but it was not until five weeks afterwards that attempts were made to contact the couple and it was a further five days before that was achieved, which was an unacceptably long delay.

In September 2006, a month after initial contact was made, Ms. V had her first face to face meeting with a social worker and confirmed she wished the child to be adopted and requested that he/she be placed with Mr. and Mrs. A.

Child V was born in October 2006 and was kept in hospital for treatment until November.

There were a number of difficulties for agencies throughout to engage with the couple due to their lifestyle and lack of co-operation but there was a recognised need to attempt to involve them. In this case it should be the norm that all agencies plan between them the best and most co-ordinated way of making contact. There are also concerns that the allocated social worker went on leave without making contingency arrangements or informing agencies of the situation.

Immediately following the child's death, Social Worker 1 arranged to visit Ms.V and Mr.V but this was cancelled due to Ms V's distress at what had happened. Social worker 1 saw the couple about the inquest and spoke to them about the process. The level of care, practice and support during this period for the couple was good.

6.6 Agency involvement with Child V

Following Child V's birth in October 2006 she remained in hospital and a referral was made to the Fostering Service for a placement. The Fostering Team Manager took the decision to place Child V with Mr. and Mrs. A, and over rule a Fostering Panel recommendation and an agency decision that another baby should not be placed with them at this time, leaving them with three children in their care.

Demand for placements is high and there are consistently a number of foster carers over their agreed placement numbers. The placement here was agreed subject to increased monitoring and support for Mr. and Mrs. A. It is concerning that this decision was taken so soon after the investigation into Child 12's admission to hospital and the Panel's subsequent recommendation. It is also concerning that the placing social worker involved was not informed of the investigation, the Panel's recommendation or the agency decision.

After discharge, Child V spent 51 days living with the couple until her death. A social services officer and a social worker visited the family six times during this period. The Fostering Supervising Social Worker however, only visited once. It was considered that Mr. and Mrs. A were coping well with Child V, had identified issues and were receiving medical support for them. Overall, there is no evidence of extra support being provided.

A Health Visitor also visited the family on three occasions and various health issues were identified and discussed. On the last visit she advised Mrs A to take Child V to the GP regarding her weight loss but this was not done. Problems with feeding and possible weight loss had been discussed during a previous visit.

The Foundation Trust's only contact with Child V was for a blood test after her discharge. Arrangements have now been changed and a follow-up review will take place for babies discharged from SCBU after treatment for Neonatal Abstinence Syndrome.

7. Conclusions

- 1) Child V sustained serious non-accidental injuries whilst in foster care, which did not contribute to her death. There is no evidence that any agency should have identified those injuries at the time.
- 2) There has been a lack of critical analysis of the assessment of the

foster carers and their care, made worse by the inadequate level of supervision and review.

- 3) The reviews throughout the couple's recruitment and fostering career suggest the Fostering Service is overstretched and struggling to meet demand. Fundamental change is needed to address this issue.
- 4) The decision to place Child V with Mr. and Mrs. A was, in hindsight, inappropriate. However, even without the benefit of hindsight the placement decision was poor based on the information available.
- 5) The Fostering Service needs to develop more independent scrutiny of carers and not let the relationship between them and their fostering social worker inhibit any investigations.
- 6) The response of social care to Ms. V's pregnancy was too slow and insufficiently robust.
- 7) There are good examples of interagency communication in this review but there are also a number of examples of poor practice in this area. The importance of good communication, both between and within agencies, cannot be overemphasised.
- 8) There was a recurrent problem in health visitors failing to identify growth problems in children in the couple's care or not taking action to have these issues assessed.
- 9) There are many examples of good practice and compliance with procedures, in particular the interventions by the Foundation Trust.

8. Recommendations

Recommendations to Rotherham Foundation Trust

Recommendations from the IMR:

- 1 The Medical Director of the Trust will ensure that a policy is introduced that requires paediatricians to offer at least one follow up review for babies with Neonatal Abstinence Syndrome who require drug replacement.
- 2 The Medical Director of the Trust will ensure that Discharge planning meetings for babies with Neonatal Abstinence Syndrome are used to highlight to parents and carers that late withdrawal can occur and they must seek medical help for withdrawal symptoms without necessarily waiting for routine outpatient review. This will be achieved by regular audit and review.
- 3 The Medical Director of the Trust will ensure that Guideline documents and parent information leaflet are amended to inform parents and carers of babies with Neonatal Abstinence Syndrome that late withdrawal can occur and they must seek medical help for withdrawal symptoms without necessarily waiting for routine outpatient review.
- 4 The Medical Director of the Trust will continue implementation of a new chart piloted on maternity wards / SCBU regarding observations of parenting, including that of foster carers.
- 5 The Medical Director of the Trust will ensure that the Designated Nurse –

Looked After Children can contribute to Level 3 training so that staff can be aware of her role and the “Looked After” process.

- 6 The Medical Director of the Trust will ensure that foster carers details are included in the new Multi-Disciplinary Records on Children’s Wards.
- 7 The Medical Director of the Trust will ensure that Level 3 training makes clear to staff their roles and responsibilities re – discharge planning, including when a child is “Looked After” This will be evaluated through course feedback and audit.

Recommendations by the Serious Case Review Panel:

- 1 The Medical Director of the Trust will ensure that a system is developed that allows non-attendance at medical appointments by children who are fostered to be identified and communicated to the Fostering Service. This will enable the Fostering Service to identify and take action in respect of trends in the behaviour of individual foster carers. (See Panel recommendation 1 to Rotherham PCT and Panel recommendation 5 to Children and Young People’s Services (Social Care)).
- 2 The Medical Director of the Trust will ensure that the Discharge Planning Protocol is reviewed to ensure that it specifies that a specific Discharge Planning meeting should take place for all Looked After Children. This should specify the timescale within which this should take place.

Recommendations to Rotherham Children and Young People’s Service (Social Care)

Recommendations from the IMR:

1. The Directors of Locality and Targeted Services will review the training for prospective foster carers, with particular regard to the implications of contact arrangements including the prospect of late changes to arrangements.
2. The Directors of Locality and Targeted Services will ensure that children being accommodated and placed from the SCBU are subject to fully documented multi-agency plans before any placement, and that these plans are discussed with prospective Carers. These will be formulated at a multi-agency pre-discharge meeting.
3. The Director of Targeted Services will require the fostering supervising social worker to make additional contact within the two weeks of all new placements, the expectation being a minimum of two contacts per week, at least one of them a visit to the placement.
4. The Director of Targeted Services will ensure that exemption decisions (i.e. to exceed the usual fostering limit of three) or those to place children outside a carer’s approval category are approved by the Service Manager for LAC, the Agency Decision Maker or a C&YPS Director.

5. The Director of Targeted Services will ensure that decisions that counter agency decisions are approved by the Agency Decision Maker or a C&YPS Director.
6. The Director of Targeted Services will ensure that the chronology at the front of Foster carer files should be kept up to date and should include:
 - Names and dates of all placements
 - Dates of reviews
 - Records of issues of concern raised by any parties other than the fostering supervising social worker or the carers themselves.
7. The Service Manager for LAC will ensure that foster carer training requirements are monitored by fostering supervising social workers. Training recommendations made by Fostering Panel Reviews should include the period by which the training should commence. All training undertaken, with details such as dates, qualifications if any, etc. should be clearly recorded and accessible as a single learning set / history.
8. The Directors of Locality and Targeted Services will make arrangements to ensure that Foster Carer Reviews are chaired by an independent reviewing officer or team manager.
9. The Directors of Locality and Targeted Services will ensure that team managers and locality managers undertake regular sampling/audit of case files using the Social Care Audit Tool, to monitor compliance with regulations and organisational policy and procedure.

Recommendations by the Serious Case Review Panel:

1. The Director of Targeted Services will ensure that a written document is produced specifying the extent of the powers delegated to the Team Manager Fostering as required by Standard 5.3 of the National Minimum Standards for the Fostering Service. This should not include overruling an agency decision without that person's agreement.
2. The Director of Targeted Services will ensure that a decision to make placements out of approval category, over the agreed fostering limit or against specific conditions for any foster carer is recorded in writing along with any special conditions attached to the placement.
3. The Director of Targeted Services will review its policy for foster carer training to ensure compliance with standard 23 of the National Minimum Standards. Particular attention should be given to ensuring that where two adults in a household are both approved as foster carers they should both receive all training.
4. The Director of Locality Services will ensure that social work staff carry out formal statutory visits to looked after children and use the correct paperwork to record these visits.
5. The Director of Targeted Services will ensure that a system is developed

within the Fostering Service to identify and take action in respect of trends in the behaviour of individual foster carers with regard to missing medical appointments for the children they foster based on information provided by Rotherham Foundation Trust and Rotherham PCT. (See recommendations and)

Recommendations to NHS Rotherham

Recommendations from the IMR:

1. The Designated Nurse for Looked After Children should include in the Standard for Looked After Children and Health Visiting that all children under 5-years of age in Local Authority Care should have a centile chart within their Health Visiting record which contains historical as well as current information.
2. The Head of Children and Young People's Services in the PCT should identify a means of recording issues relating to the parenting capacity of Foster Carers on TPP (the PCT client information system) to allow a holistic picture to be developed of parenting capacity by ensuring that issues such as defaulted appointments, growth issues and injuries can be recorded while preserving the anonymity of the child in placement.
3. Each foster carer should have a named health visitor who will incorporate an assessment of that foster carer's ability to meet the developmental needs of each individual child in placement within her visiting plan. A minimum of three visits each year will be expected with guidance being provided by the PCT as to the content of those visits.

Recommendations by the Serious Case Review Panel:

1. The Head of Children and Young People's Services in the PCT will ensure that a system is developed that allows non-attendance at medical appointments by children who are fostered to be identified and communicated to the Fostering Service. This will enable the Fostering Service to identify and take action in respect of trends in the behaviour of individual foster carers. (See Panel recommendation 1 to Rotherham Foundation Trust and Panel recommendation 5 to Children and Young People's Services (Social Care)).
2. The Head of Children and Young People's Services in the PCT will ensure that weights should be recorded by staff in kilograms not in pounds and ounces.

Recommendations to Rotherham Children and Young People's Service (Early Years Service)

1. The Workforce Development and Quality Assurance Co-ordinator will commission training to ensure that:
 - a. Early Years child care settings and child care providers understand roles and responsibilities and the processes and procedures to follow for looked after children

- b. Early Years child care settings and child care providers understand the level of contact and information sharing they can expect and request from the social worker for a looked after child
2. The Workforce Development and Quality Assurance Co-ordinator will review guidance to settings to reinforce the above.

There are no recommendations to Rotherham Children and Young People's Service (Early Years Service) from the Serious Case Review Panel.

There are no recommendations to CAFCASS, South Yorkshire Police or Children & Young People's Service (Education – Inclusion, Voice and Influence) from either their Individual Management Reviews or the Serious Case Review Panel.

Rotherham Safeguarding Children Board will ensure the implementation of these recommendations to agencies through the close monitoring of a detailed action plan.

This Executive Summary was written by Steve Pearson, Communications Manager, Children & Young People's Services, in consultation with Peter Ward, Independent Overview Author, and Jim Stewart, Safeguarding Children Board Manager.

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