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Serious Case Review

Child F

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Contents

1 Executive Summary

1.1 This serious case review has been commissioned by Darlington Safeguarding Children Board following the admission of Child F to hospital on 19.4.18. He had ingested a number of Tramadol tablets that had been prescribed for his mother.

1.2 Child F had been subject to care proceedings immediately after his birth due to concerns about Mother's ability to parent him, as she had previously had 3 children removed from her care under the category of neglect.

1.3 The purpose of the review was to establish whether there is learning in relation to the existing policies, procedures and practice standards and the implementation of them by practitioners. A number of specific questions were developed by the rapid review panel and are answered in section 12 of this report. The full terms of reference for this review are given at appendix 2.

1.4 This review seeks to make improvements whilst protecting the vulnerable people involved in this case. Therefore, anonymity is protected by keeping the details of the family to a minimum throughout, in terms of names and key dates that may identify individuals.

1.5 Darlington Local Safeguarding Children Board commissioned the independent author to undertake the review using the root cause methodology. The findings outlined in this report come from analysis of the case by a team of practitioners, facilitated by an experienced reviewer and the author. The aim of the process is to establish what happened, and what could have been done differently and not to attribute blame to any individual. The findings reflect changes that can be made in professional practice (NSPCC/SCIE 2016).

1.6 The author found 3 root causes as a result of this investigation:

- Practitioners were overly optimistic about the Mother's ability to parent Child F.
- Mother displayed disguised compliance or "faking good".
- Tramadol was readily available in the family home

1.7 There were also a number of contributory factors identified which are shown in section 11.

1.8 As part of the review process 9 recommendations were identified and are shown in section 13. These will be implemented by the relevant agencies and followed up by the Darlington Safeguarding Children Board. Agencies involved are also all expected to determine whether there is further learning required within their agency as a result of this report.

1.9 The author would like to thank the Lead Reviewer, the staff that contributed to the various meetings and the Darlington Safeguarding Children Board business unit for their support in undertaking this review.

2 Introduction

2.1 This serious case review considers Child F, who was born in December 2014 at 37 weeks gestation. Child F's Mother had had 3 previous children removed from her care under the category of neglect. Child F was a Looked After Child from 19.12.14 until 29.9.15 when he was placed back into the care of his Mother.

2.2 On 19.4.18 Child F was brought to Darlington Memorial Hospital (DMH) following a 999 telephone, call from his Mother indicating that his eyes were rolling and that he was sleepy and lethargic following possible ingestion of Tramadol.

2.3 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.

2.4 A report by Consultant Paediatrician 2 (CP2) was considered at the Case Review Panel meeting held on 6.12.18. This stated that "From the information I have available…… I feel that any long term effects on Child F's development and long term health as a direct result of the Tramadol ingestion are unlikely to be significant". Despite the findings of this report the panel concluded that there were significant incidents of concerns and potential missed opportunities leading up to the event where Child F ingested Tramadol.

2.5 As a result of these events, this serious case review has been commissioned by Darlington Safeguarding Children Board (DSCB) in accordance with Working Together 2018 (HM Gov 2018).

2.6 The author of this report, Gillian Findley, is a Registered Sick Children's Nurse and a Registered General Nurse with over 30 years' experience of working with children and adults as a front line worker, as a manager and as a director responsible for safeguarding. She has worked in health in various organisations as a lead professional for safeguarding and patient safety. She has undertaken and written many reports using root cause methodology and has studied human factors and human error at masters' level. At the time of the incident the author was the Director of Nursing and Quality for North Durham and Durham Dales, Easington and Sedgefield Clinical Commissioning Groups. She had had no involvement with the child or with the practitioners involved in the care of the child and family at that point.

2.7 The lead reviewer is Bev Walker who is a Registered General Nurse and a Qualified Midwife. She has 40 years' experience working in a range of clinical areas caring for adults. She has had a variety of roles across and number of NHS organisations, which have included working in assistant and deputy director of nursing posts with lead responsibility for both adult and children's safeguarding and patient safety. In these roles she has led a significant number of incident investigations using a number of methodologies including root cause analysis. At the time of the incident the lead reviewer was a Safeguarding Adults Lead for North Durham, Durham Dales, Easington and Sedgefield and Darlington Clinical Commissioning Groups. She had no involvement with the child or with any practitioners involved in the care of the child and family at that point.

3 Terms of Reference

3.1 This serious case review covers the period from 1st June 2014, the day before Child F's Mother self-referred to the early pregnancy assessment unit within County Durham and Darlington NHS Foundation Trust (CDDFT) through to the date of the incident (ingestion of Tramadol) on 19.4.18. The author and the review panels were also able to access historical information of relevance.

3.2 To protect anonymity the subject of the investigation is referred to as Child F throughout. Other people are referred to by their relationship to the child e.g. Mother, Father, Maternal Aunt etc. Professionals are referred to by their role e.g. social worker 1, social worker 2 etc.

3.3 The full Terms of Reference for the review are shown at appendix 2.

4 Involvement of the Family

4.1 Numerous attempts have been made by children's social care, facilitated by the business unit of the DSCB to involve the Mother of Child F in the review, but she has to date, declined to be involved. She has also refused consent for the author to access her full medical records. In order to complete the review and understand the impact of the Mother's health on events, in accordance with section 27 of Working Together (HM Gov 2018) the author sought, and was granted permission, from the Caldicott Guardian of CDDFT and GP practice to access records only in respect of those matters relevant to the case (Caldicott 2013). This information was not shared with the Root Cause Analysis (RCA) meeting.

4.2 The business unit of DSCB has had no contact from Father in relation to the serious case review. Consent for review of Father's medical records was not given. Child F's Father was not an active part of his life and so is not considered further in this report. Maternal Grandmother is aware that the serious case review is being carried out. Brother 1 consented for the author to access his records, but this was not felt to be necessary.

5 Process/Methodology

5.1 Darlington Case Review Panel determined that using root cause analysis investigation techniques would be the most appropriate methodology to investigate the circumstances surrounding Child F ingesting Tramadol on 19.4.18. Root cause analysis is one of a number of techniques that is accepted to review serious child safeguarding cases (DSCB, 2019).

5.2 Root cause analysis is a series of techniques deriving from the airline and chemical industries (Vincent 2006; Charles et al 2017) where a review panel seeks to explore the circumstances that led to an incident occurring. Root cause analysis is based around a 'no blame culture' where the team looks at systems and processes alongside individuals' actions. 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

5.3 In this case, the process of undertaking the root cause investigation was as follows: each agency was asked to put together a single agency chronology of their involvement with the family during the period outlined in the scoping document; the single agency chronologies were then merged into one document. The lead reviewer and the author then identified key lines of enquiry arising from the merged chronology. These key lines of enquiry also included areas of notable good practice.

5.4 A managers' briefing meeting was held on 30.4.19, followed by a practitioners' event on 8.5.19. The practitioners' event on 8.5.19 is referred to throughout this report as the Root Cause Analysis (RCA) meeting. A list of the agencies who have contributed to the panels is shown at appendix 3.

5.5 At the RCA meeting the lead reviewer and the author explored the key lines of enquiry with the representatives from the relevant agencies. In discussion with the practitioners, the lead reviewer and the author identified a number of key themes arising from the discussions. These were explored further and root causes were established. Actions and learning arising from the root causes were then developed by the practitioners. This report has been produced using these findings and the other information available to the author. A follow up learning and improvement meeting was held on 11th June 2019 to share the draft report with practitioners and correct any factual inaccuracies.

5.6 A list of the sources of information that were available to the author is shown at appendix 4. It includes: single agency chronologies, medical reports and meeting minutes.

5.7 The author considered whether cultural and diversity factors played a role within the case, but there were not felt to be any issues of note. Mother was found to have a congenital hearing loss, but practitioners described her being able to communicate effectively with them without the need for additional support.

6 Background from the Merged Chronology

6.1 In this section the key points from the merged chronology are investigated and key lines of enquiry are established.

6.2 On 2.6.14 Child F's Mother self-presented to the early pregnancy assessment unit at DMH, she was 12 weeks pregnant. She attended a booking appointment with Community Midwife 1(CMW) on 27.6.14. Due to a family history of a genetic condition her antenatal care was shared between CDDFT and the RVI. This is usual practice.

6.3 Her pregnancy progressed without incident apart from some back pain at 16 weeks, for which she was prescribed an appropriate dose of codeine.

6.4 The CMW was aware that Mother had delivered all 3 of her previous children early and so she repeatedly asked social care staff to arrange a strategy meeting. Following a pre-birth assessment by social care professionals that started on 1.7.14, a strategy meeting was held on 12.12.14 and a pre-birth plan was agreed that included Child F becoming Looked After immediately after birth. There appears to have been a lengthy delay between the assessments and the strategy meeting taking place. This is discussed further in section 7.2.1.

6.5 It was noted that the GP records were not available at the pre-birth strategy meeting. It was however felt that this did not materially impacted upon the strategy meeting decision.

6.6 In December Child F was born at DMH at 37 weeks gestation. After a short stay in the special care baby unit (which is appropriate in such cases), he was discharged to foster carers on 23.12.14. This is accepted practice.

6.7 GP records showed that Mother had some post-natal depression. It is reported that this was appropriately managed with medication for a short period of time.

6.8 After his birth Child F was accommodated in a foster placement. It was noted that the Foster Mother worked well with Mother and this was seen as a positive. The Foster Mother reports Child F's Mother interacting well with him and caring for him appropriately.

6.9 In the immediate ante and post-natal period Mother attended a significant number of assessments and developmental programmes. This is discussed further in section 7.2.5.

6.10 As part of the assessment process Darlington Borough Council commissioned a forensic psychology report from Consultant Psychiatrist 1 (CP1). The report dated 8.4.15 has been made available to the author. It appears that selected parts of the report were made available to some professionals in children's social care, but the full report was not available to all agencies so the information could not been seen in context. This is discussed in sections 7.3.5 to 7.3.8.

6.11 In the period from 8.4.15 to 28.9.15 Child F was seen by a number of professionals including GP, Health Visitor and Early Year Practitioners. These attendances and reviews are all seen as positive and Mother's parenting is reported to be appropriate during this time.

6.12 Following the completion of the assessments and parenting programmes outlined above on 29.9.15 Child F, now 9 months old, ceased to be looked after and was placed back in the care of his Mother. Social Worker 1 was to stay involved for 8-12 weeks. This was felt to be within the bounds of acceptable practice.

6.13 On 26.11.15 Child F started at the nursery. Nursery staff report good interaction between Mother and Child F and that he was a happy and lively child. He continued to attend until 12.5.16. During this period there were no reported concerns from the nursery.

6.14 On 27.11.15 Mother requested a visit from Health Visitor to discuss feeding as Child F was reported to have stopped eating finger foods. This visit took place and a follow up visit was scheduled for 4.12.15.

6.15 On 4.12.15, following an ineffective visit, the EYP and Mother had a conversation in which Mother disclosed some bruising to Child F's legs. Following a conversation between EYP 1 and Health Visitor 1 a referral was made to social care and this resulted in a referral for an assessment by a Paediatrician at DMH. The explanation that was given by the Mother was deemed to be plausible by Consultant Paediatrician 1 (CP1). This is discussed further in section 7.4.3.

6.16 On 24.1.16 Child F was brought by ambulance to the emergency department (ED) at DMH at 22.53hrs with Brother 1 and Mother. Child F was found to have an upper respiratory tract infection. During this attendance concerns were noted by the ambulance crew and the ED staff and a referral was made to social care by ED staff. ED staff were told that the case was closed by the emergency duty team in social care. This sequence of events is discussed in more detail in sections 7.4.4 to 7.4.7.

6.17 Between 24.1.16 and 30.8.16 there were at least 10 recorded face to face meetings or visits where Child F and his Mother were seen by various professionals. This included visits from EYP, Health Visitor, GP and Paediatrician as well as "child in need" meetings. There are no reported safeguarding concerns from any of these interactions.

6.18 On 31.8.16 Child F's case was closed to statutory children's social care. He was 20 months old at this point.

6.19 From 3.1.17 to 22.2.18 Child F again attended the Nursery for 3 half days per week. During this time, he had a high absence rate, not attending on 35 occasions. This was attributed to a number of childhood illnesses including what was described as toddler diarrhoea. There were also 4 reported incidents of bruising reported by Mother (7.3.17; 8.3.17; 6.10.17 and 2.11.17). Mother gave what was seen as a plausible explanation for all but the incident on 6.10.17 when she said she did not know how this bruising had happened. These issues are discussed in more detail in section 7.4.13.

6.20 The Nursery made a referral to children's social care in relation to concerns that Child F was sometimes unclean and his nappy needed changing on arrival at nursery. This referral was judged not to meet the threshold for intervention. The RCA meeting agreed with this judgement on the basis of the information available at the time.

6.21 On 22.11.17 there was a meeting held to discuss some emerging behavioural concerns. Child F was presenting as aggressive and not responding to discipline and he was sometimes dirty and had a soiled nappy when he attended the nursery. Mother declined early help. This point is discussed in more detail at section 7.4.14.

6.22 From 06.07.15 until the end of the review period Mother was prescribed Tramadol for back pain. The dose prescribed was always within therapeutic range, but was increased over a period of time, up to 200 tablets per month from October 2017. It was reported that many of the professionals involved with Child F were unaware that Mother was prescribed Tramadol.

6.23 On 19.4.18 Child F was admitted to DMH following ingestion of Tramadol. Mother had called 999 saying that he was sleepy and lethargic and his eyes were rolling. Mother said that he may have taken some of the Tramadol that was prescribed for her.

6.24 On the same day (19.4.18) Child F was transferred from DMH to the RVI and was admitted to paediatric intensive care. It is reported that he had a respiratory arrest and then a cardiac arrest. It is likely that the respiratory and cardiac arrest were a consequence of the ingestion of Tramadol and subsequent resuscitation measures. It is unclear how much Tramadol he had ingested or whether he took it accidentally or had it administered to him.

6.25 During this admission there were differences of opinion as to the course of events that led to Child F's admission and Mother gave differing accounts of the circumstances. This is the subject of police investigation and is outside the scope of this review.

6.26 It is reported that it was difficult to wean Child F from the ventilator, but he was successfully extubated on 24.4.18.

6.27 The arrangements for discharge and subsequent follow up of Child F are out of the scope of this review, but it is worthy of note that, during the admission, there was a body of opinion amongst the professionals who felt that the ingestion was a tragic accident. There were discussions about instigating care proceedings, but these did not go ahead mainly because Mother was seen as compliant and family support was seen as strong.

6.28 Out of the scope of this review, a hair strand test taken from Child F on 4.5.18 was reported on 14.5.18. This report showed that Child F had had Tramadol and amphetamines in his system for an extended period of time and suggested more than 1 episode of ingestion. Child F was placed with Maternal Grandmother on 7.6.18 as a Child Looked After. He remains with Maternal Grandmother on an interim care order. The author has been informed that court proceedings are continuing.

7 Findings

7.1 Using the key lines of enquiry identified in section 6, and the discussions from the RCA meeting, the author discusses here the findings from the review. The findings are divided into 3 sections: pre-birth, birth and immediately post-delivery and early years.

7.2 Pre-Birth

7.2.1 It is usual practice for a pre-birth plan to be agreed as soon as serious safeguarding concerns come to light. This usually occurs at around 28 weeks, which is the date at which most pregnancies are thought to be viable. This did not happen in the case of Child F. The social care assessment was started in July 2014, but the strategy meeting at which the pre-birth plan was agreed was not held until 12.12.14, when Child F's Mother was 36+ weeks pregnant. The reason for this delay is not clear. The RCA meeting was told that procedures had been changed since this time and planning now takes place at 28 weeks, with a more robust process of challenge between agencies in the event that this does not happen.

7.2.2 On 21.12.14 there was a "Letter Before Proceedings" meeting. This appears to have happened later in the process than would be expected. Best practice would have been for this meeting to have taken place before the baby was born to prevent Mother being required to make big decisions shortly after giving birth.

7.2.3 During the pre-birth planning phase there was some consideration given to whether a place could be found at a mother and baby unit. It appears that this option was rejected at the Darlington Allocation of Resource Panel (DARP). It is not clear whether this was rejected on the grounds of finance or whether those present felt professionally that it was not a suitable option. It is not clear what the status of DARP would be if the professionals felt strongly that a mother and baby unit would be the best placement option. DSCB should consider the role of DARP in safeguarding cases in order to clarify this.

7.2.4 On booking with CMW1, Child F's Mother disclosed that she had had previous children removed from her care. A referral was then made to children's social care by CMW1 to allow a pre-birth assessment to be undertaken. Knowing that Mother had delivered all her 3 children early, CMW1 was tenacious in making sure the strategy meeting took place. This is seen as notable good practice.

7.2.5 During the antenatal and immediate postnatal period there were requests for Mother to attend parenting classes, stop smoking sessions, and other assessments both in County Durham and in Newcastle. There was discussion at the RCA meeting about whether these were excessive requests for the Mother. On at least one occasion she was late arriving and she had to leave early due to transport issues.

7.2.6 In addition, the author noted that Mother has congenital hearing loss. There is no mention of whether reasonable adaptations were considered or required. It is therefore not clear whether Mother had a full understanding of what she was being asked to do by professionals. However, practitioners described Mother as being able to respond and communicate effectively with them without the need for additional support.

7.3 Birth and Immediately Post Delivery

7.3.1 Child F was delivered in December 2014 at 37 weeks gestation. After a short stay in SCBU he was discharged to foster carers on 23.12.14.

7.3.2 The RCA meeting felt that, at this point, the practitioners were concerned about getting an outcome as to whether Child F could return to his Mother as quickly and safely as possible, being mindful of the fact that outcomes are better where children are placed early (Munro 2001). This was seen as good practice and viewing the situation through the child's eyes.

7.3.3 Immediately after birth, Child F's Mother was noted to be engaged in a number of actions including: ongoing assessments; attending a parenting programme; attending a "Freedom Programme"; attending the drug and alcohol service and undertaking a forensic psychology assessment. On 22.05.15 Mother was requested to self-refer for anger management, but it appears that she did not do this. This issue was not followed up and it appears that she did not attend this. Again, there was discussion about what support Child F's Mother had to attend all these appointments in the post-natal period and whether the demands on her were excessive as she had just given birth. It was felt that an earlier pre-birth plan would have spaced out the requests better and been less demanding on Mother.

7.3.4 There were also questions about whether there was an overreliance on parenting programmes in the plan to work with the Mother.

7.3.5 During this assessment phase, Darlington Borough Council commissioned a forensic psychology assessment of Child F's Mother with Consultant Psychiatrist 1 (CP1). This took place and the report dated 8.4.15 has been made available to the lead reviewer and to the author. This report contains some very important information in relation to Mother's mental health and ongoing care needs.

7.3.6 CP1 reports on the psychometric tests undertaken by Child F's Mother saying: "her assessment of anger was negatively influenced by issues of social desirability (faking good)". Had this information been available to front line practitioners they may have been more alert to the potential for the Mother to display "faking good" or "disguised compliance" (Brandon 2008; HM Gov 2016). Disguised compliance was felt to be an important factor in this case as discussed in section 7.4.21. The report from CP 1 goes on to explore issues in relation to substance misuse saying: "in the longer term there remains the potential that she may destabilise psychologically if her life becomes more difficult or should she fall under the negative influence of others, especially within intimate relationships. In such circumstances, substance misuse will offer an option for self-medication against psychological and emotional distress and compromise issues of parenting, as well as her own behavioural control." It is difficult to say whether practitioners would have reacted to this information had they been made aware of it and, although this sentence appears to relate to use of illicit substances, it later becomes important with regard to the use of prescribed medication. This is explored further in section 7.4.20.

7.3.7 The RCA meeting considered why actions that were requested in the forensic psychology report were not followed up, specifically the suggestion that Child F's Mother should have hair strand testing and blood tests at random intervals. This was probably because the report was not widely shared. It was noted that it is likely that these tests would have shown some level of opiate use related to her prescribed medication (codeine and Tramadol) but some participants in the RCA meeting felt that this would have raised the profile of the prescribed medication in Mother's care and would have led to conversations about safe storage and monitoring of drug use.

7.3.8 Overall the decision not to share the findings in the report of CP 1 was felt to be a significant factor in the events that followed for Child F. It may be that this did not happen because it was requested in preparation for court proceedings rather than specifically for Mother's ongoing management. DBC should review whether information sharing should be strengthened at this point in a case.

7.3.9 Child F was born with a genetic abnormality in the SHOX gene. This is a gene related to Turners Syndrome and so gives short stature as it mostly affects the development and maturation of the skeleton. It is not clear at this stage what impact this will have on his future development. It will also make it difficult to determine whether any developmental delay in the future is due to the short period of time his brain was without oxygen in hospital as a result of the ingestion of Tramadol, or whether it is an inevitable consequence of the genetic condition that he has. It was not however, felt to be a significant factor in the incident under investigation.

7.4 Early Years

7.4.1 The RCA meeting noted that there were a number of meetings including the Legal Gateway Meetings and Letter Before Proceedings meetings that were, at the time, held as single agency meetings. In the case of Child F some of the meetings were making important decisions that were not discussed with other agencies, for example, the "Letter Before Proceedings" meetings held on 12.1.15, 22.4.15 and 21.1.16. The RCA meeting was informed that the procedures within Darlington Borough Council have now changed and notes of these meetings are shared with other agencies. DSCB should review whether this is sufficient to ensure that all relevant information is available to agencies making decisions in relation to a child's future and whether all decision making is shared where appropriate.

7.4.2 On 27.11.15 there was planned visit to Mother's house, at her request, due to feeding issues. A planned follow up visit by the EYP on 4.12.15, was ineffective. However, during a telephone conversation between Mother and the EYP, Mother stated that child F had bruising to his legs, which she thought was from holding him too tightly during a nappy change. This information was passed to Social Worker 1 the same day and he immediately asked for a paediatrician review. This rapid passing on of information between agencies and professionals was seen as notable good practice.

7.4.3 Paediatrician 1 who saw Child F on 4.12.15 reported that the explanation for the bruising was plausible. At the RCA meeting there was some concern about this view and it was felt that there should have been professional challenge at the time of the appointment and that perhaps the need to challenge was not recognised. Some practitioners felt that it would be difficult to challenge the view of a paediatrician in relation to such clinical matters. This reluctance to challenge is well documented in hierarchical health settings for example, in an operating theatre (Bromiley 2008, Beament 2016). There may have been an element of hierarchy operating between the health visitors, social workers and the paediatrician at this point. Agencies should review the nature of such interactions and use this case as a learning tool to promote a cultural change. In addition, DSCB should consider whether their policy on Professional Challenge (DSCB, 2018) is sufficiently robust or whether additional requirements to strengthen professional challenge in the safeguarding setting should be considered.

7.4.4 On 24.1.16 Child F was taken to DMH GP out of hours following a 999 call in relation to constipation, temperature and walking on tiptoes. On this occasion he was reported by staff in the department as being "unkempt" and in wet clothing. Brother 1 was also in attendance and was said to be prompting his Mother to undertake the care for Child F. A referral was made to the social care emergency duty team by the department staff. This is expected practice.

7.4.5 On 24.1.16, there was discussion between the ambulance crew and the ED staff about there being many cans of alcohol in the house when they attended. This was not investigated further but could have been an opportunity for escalation of the case.

7.4.6 It is reported that staff in the ED were told by social care that the case had been investigated and was closed. It remains unclear why this information was passed to the ED staff as it was incorrect. At this point, children's social care did not react to further concerning information being reported about the case and this could have been a trigger for further work with the family.

7.4.7 Whilst it is accepted that it was good practice to make the referral to social care, there does not appear to have been any professional challenge when ED staff were told by social care that the case was closed. The attendance on 24.1.16 could have been an opportunity for professionals who were unfamiliar with the family to provide an assessment of Child F's life and home surroundings but this opportunity, to challenge the prevailing view amongst the professional team closest to the family that Mother was coping well, was missed.

7.4.8 There was further discussion about the role of Brother 1 during this attendance at ED. At the time Brother 1 was 14 and was himself a child. There does not appear to have been any record of his being in a young carer's role and what his role was in the family home. It appears that he was not seen as a child in this setting. Brother 1 was under the care of Maternal Great Grandmother at the time under a special guardianship arrangement. It is not documented whether his guardian was present during this attendance.

7.4.9 During the RCA meeting it was noted that Brother 1 had started to attend his Mother's house on for regular visits. The gradual return of Brother 1 to the family home was discussed and it was felt that, at the time, this was seen as a positive influence on Mother, but it was acknowledged that his needs had not been fully considered during this episode. The RCA meeting was advised that his needs had subsequently been reviewed and he was now safeguarded appropriately.

7.4.10 EYP 1 made a visit to the family home on 26.1.16 to follow up after the ED attendance. Unfortunately, this visit was ineffective. However, the attempt to follow up an ED visit with a face to face discussion was seen as good practice. A further visit was successfully made on 4.2.16 with the Health Visitor. The RCA meeting was told that, at this point, Mother was still engaging well with services, family support was felt to be good and despite an episode of bruising and a worrying emergency department attendance, practitioners were continuing with the plan to withdraw additional statutory support and move to universal services. There appears to have been a rule of optimism among professionals at this stage with negative emerging findings being too easily accepted as having plausible explanations and not considered in the context of historic information.

7.4.11 On 31.8.16 the case was closed to statutory children's services. This means that monitoring of the child and family would become the remit of universal services (i.e. health visitor and GP). There does not appear to have been a clear plan as to how this monitoring would take place.

7.4.12 There was discussion at the RCA meeting about whether the period when Child F was a child in need was a meaningful period of time for the family or whether the case was allowed to drift. It was felt that professionals were passively rather than actively managing the case at this time.

7.4.13 Between 3.1.17 and 22.2.18 Child F attended the Nursery for a second period of time. During this time 4 injuries are recorded, each having been identified to staff by Mother. At the RCA meeting practitoners reported that Child F was generally happy and full of energy and would run to greet Mother when she came to collect him. The explanations that Mother gave for the injuries were consistent with that of an active toddler of his age. It was not felt to be unusual for the injury on 6.10.17 to be unexplained, given his presentation as an active toddler. However, it may have been a sign that Mother was finding it increasingly difficult to cope.

7.4.14 From late 2015 onwards, the RCA meeting identified that there were several comments noted that indicated that Mother was starting to decline help such as: "prefers to manage alone"; "Mother declined early help referral" and Mother was "feeling judged" at the nursery. It appears that these comments were taken at face value and not investigated further. The RCA meeting felt that when taken together with the incidents reported above they showed a decline in Mother's parenting that was not picked up by professionals at the time, potentially because the level of intervention from professionals was decreasing just at the time when Mother's needs were increasing.

7.4.15 There was discussion at the RCA meeting about whether the introduction of the Sign of Safety tool would facilitate more professional discussion about concerns. Signs of Safety is a strengths-based approach where, considering all the current risks and positive influences, practitioners rate the current situation on a scale of 0-10. Professionals then work with families to put together a plan to improve the rating (DfE 2017).

7.4.16 Professionals felt that not all agencies had an understanding of Signs of Safety and in some cases, scoring was being used within meetings to try to gain consensus rather than as an improvement tool. DSCB partners should consider whether Signs of Safety should be used by agencies and if so, all agencies must have a consistent understanding of its use.

7.4.17 At the RCA meeting there was discussion about why there was Tramadol in the house. The GP was able to share that Mother had reported increasing back pain following the birth of Child F. Tramadol was prescribed in an appropriate dose during this period. It was however, noted that the amount that Mother requested had been increasing gradually and although this had been explored and subsequently a referral was made for back surgery; there was no check as to whether other agencies were aware of the Tramadol use by Mother. It is the prescriber's responsibility to ensure that the patient knows how to store and manage any prescribed medication. It is not clear from the GP records whether this was discussed with Mother.

7.4.18 There appears to be a discrepancy about what Mother said to various professionals about her use of Tramadol. Members of the RCA meeting felt that, if they had been aware that there were significant amounts of Tramadol in the house, they would have had conversations with Mother about safe storage and handling of the medication. This would also have alerted Mother that professionals were looking at her use of medication.

7.4.19 There was also discussion at the RCA meeting about whether conversations about drug use did not take place because professionals did not see the dangers and potential abuse of prescribed medication. The attendees felt that had Mother disclosed the use of illicit drugs, there would have been a more inquisitive and structured response. The RCA meeting felt that professionals' knowledge of which prescribed medication could be problematic was limited and this may have affected their handling of the family.

7.4.20 The RCA meeting also discussed the link to forensic psychology report that had highlighted that use of drugs could affect Mother's parenting ability. Practitioners felt that this was not pieced together with the increasing use of prescription drugs and therefore the dangers in the household were not considered at this point.

7.4.21 The RCA meeting had lengthy discussion about Mother's presentation throughout Child F's life. The picture that was given to professionals who worked with her regularly was of a compliant Mother who was trying hard to do everything that was asked of her to keep her 4th child with her. She regularly self-referred and identified problems such as bruising and this gave false assurance that she was being open and honest. This picture is often seen in serious case reviews and is termed "disguised compliance" (HM Gov 2016). There were also features of "start again syndrome" where new practitioners coming into the family were too willing to allow Mother the opportunity to start again in her parenting (HM Gov 2016).

7.4.22 Although the discussion presented here shows and emerging picture of increased need from Mother and decreasing intervention, it was noted at the RCA meeting that this only becomes clear with hindsight. At the time, the increased concerns were not seen by practitioners working closely with the family. There was discussion about the impact of changing IT systems and reorganisations within services, but there was no evidence to suggest that this played a major part in the care of Child F or his Mother.

8 Notable Practice

8.1 During the review process a number of areas of notable good practice were identified by the author, the lead reviewer and attendees at the RCA meeting.

8.2 The CMW 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.

8.3 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.

8.4 It was felt that the EYP who attempted to follow up after ED attendances was following best practice. She was tenacious in following when these visits were ineffective.

8.5 On 4.12.15 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.

8.6 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.

8.7 At the RCA meeting, the Police noted that both the old and the new IT systems are checked within the Darlington MASH for historic information. This does not happen in all areas.

9 Eyes of the Child/Children

9.1 The author considered whether the practitioners involved had seen incidents unfolding "through the eyes of the child". It was felt that once Child F was born there was consideration to making a swift decision as to whether he would be allowed to stay with his Mother because it was felt that a prolonged period of indecision would be detrimental to him, but once the decision was made to return him to Mother's care, there is very little mention in the records of people noting Child F's experiences through his eyes.

9.2 In addition, the author considers that professionals failed to see the situation for Brother 1 during his attendance at the ED on 24.1.16. It is noted in the records that he was prompting Mother and undertaking most of the caring responsibilities, but no one asked why he was undertaking this role or how he came to be with his Mother at this time without his guardian. Brother 1 was 14 at the time and still a child himself. This was a missed opportunity to see life through his eyes.

10 Summary of Findings and Thematic Analysis

10.1 This section summarises the discussion about the key lines of enquiry, the findings of the RCA meeting, and other meetings. Recurring discussions and ideas are grouped together using a thematic analysis approach to give 7 themes (Braun and Clarke 2006).

10.2 Disguised compliance

10.2.1 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 ED 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 unware of the historical issues (the report had not been shared) and also because Mother hid the reality of her situation from practitioners. Her later assertions that she preferred to manage alone and when she declined early help confirm the view that disguised compliance was a factor. Disguised compliance was felt to be a root cause of the final incident.

10.3 Over optimism and minimising the importance of historic information

10.3.1 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.

10.3.2 In addition, there were a number of emerging negative signs that were minimised. In particular, the increasing absences from nursery, the worrying ED attendance on 24.1.16 and the increasing attendances at nursery when he was soiled or unkempt.

10.3.3 There was a lack of professional curiosity from the emergency duty team on 24.1.16, when they were informed about the concerns in ED, they said that the case was closed and did not appear to discuss the need to reopen the case or investigate further. In fact, this information was erroneous and the case was still open.

10.3.4 At the RCA 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.

10.4 Lack of Professional Challenge

10.4.1 Practitioners have been open in describing a number of occasions where there should have been professional challenge. On 4.12.15 CP1 felt 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.

10.4.2 On 24.1.16 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.

10.4.3 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. DSCP should explore this concept in training with practitioners.

10.5 Mother's physical health not taken into account

10.5.1 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.

10.6 Practitioners did not recognise the importance of the prescription drugs in the home

10.6.1 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.

10.6.2 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.

10.6.3 The author found that the fact that Tramadol was readily available in the house was a root cause of the incident.

10.7 The full picture of Mother's mental health was not known

10.7.1 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.

10.7.2 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.

10.7.3 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.

10.8 Information sharing and communication

10.8.1 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.

10.8.2 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. DSCB 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.

10.8.3 Failing to share or use the historic information from CP1's forensic psychology report is found to be a contributory factor to the incident.

11 Root Causes and Contributory Factors

*A **root cause** is defined as "a cause that leads directly to the problem" (Anderson et al 2010). On the basis information available, the author has been unable to determine whether the Tramadol taken by Child F was as a result of an accidental ingestion or planned administration. Given the ongoing police investigation it is not felt appropriate to pursue this further in this report. On the basis of the information available, the author has determined that the root causes of the incident on 19.4.18 when Child F was admitted to hospital following ingestion of Tramadol were as follows:*

11.1 Practitioners were overly optimistic about the Mother's ability to parent Child F.

11.2 Mother displayed disguised compliance or "faking good".

11.3 Tramadol was readily available in the family home

*A **contributory factor** is defined as "a cause that forms a link in the chain" of occurrences that leads to an incident (Anderson et al 2010).On the basis of the information available the author has identified the following contributory causes:*

11.4 Historic information was forgotten or not considered fully when decisions were being made.

11.5 The late development of a pre-birth plan led to excessive demands on Mother in the immediate post-natal period and an overreliance on attending parenting programmes.

11.6 All requested actions were not followed up, which led to gaps in information

11.7 Practitioner's awareness and knowledge about the dangers of prescription medications was limited.

11.8 Mother's increasing prescribed dose of Tramadol was not recognised as a concern.

11.9 There was a lack of professional challenge at a number of key points during Child F's life.

11.10 Key information was not shared with front line practitioners, for example the report of Psychiatrist 1 and notes of the LBP meetings.

12 Responses to the Questions asked in the Terms of Reference

Were there a number of missed opportunities for multi-agency challenge?

12.1 The author found that there were some missed opportunities for multi-agency challenge, for example on 4.12.15 when Child F was assessed with bruising to his legs and during the ED attendance on 24.1.16 when ED staff were told that the case was closed by social care staff.

Were there missed opportunities for strategy meetings to be held where child F could have been removed from mothers care?

12.2 Two strategy meetings were identified in the chronologies considered by the author. The first was on 12.12.14 before the birth of Child F and the second was on 20.4.18 after the ingestion of Tramadol. There were 2 further strategy meetings in May 2018, but these are out with the time period for the review. The RCA meeting considered the opportunities for additional strategy meetings but agreed that in each case the nature of the referral was such that it did not meet the threshold for a strategy meeting. However, it is possible, that had there been a review of the case, the general decline in Mother's parenting ability may have been identified and a strategy meeting may have been called. However, it is still doubtful as to whether any strategy meeting would have recommended removing the child on the basis of the information available at the time.

Is there evidence of communication between agencies?

12.3 There is some evidence of good communication between agencies for example, on 4.12.15 when the EYP informed the Health Visitor, who referred to the Social Worker, who arranged a paediatric assessment of the bruising on Child F's legs. Also the nursery communicated their concerns to social care practitioners regularly.

Is there evidence of information sharing between agencies?

12.4 The author found that there was evidence of some good information sharing between teams for example between the community midwife and social care. In addition, the information shared by the nursery was comprehensive and timely. However, there is also evidence that key pieces of information were not shared. At the pre-birth strategy meeting the Mother's GP record was not available. In addition, 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.

Is there evidence of professional challenge from any organisation?

12.5 There is limited evidence of professional challenge, mainly CMW1 insisting on a strategy meeting due to Mother's previous early deliveries. Some practitioners at the RCA meeting recalled discussions between professionals in the child in need meetings, but this is not recorded. There is also evidence of a lack of professional challenge occurring at key points in Child F's life as outlined in section10.4.

Is there evidence of professional curiosity?

12.6 The author has found that professional curiosity was lacking, particularly in relation to the ED attendance on 24.1.16 and the increasing nursery absence during 2017 and into early 2018 when Mother started to decline help and support.

Was historic information taken into account when informing decisions?

12.7 The author has found some evidence of historical information being taken into account: for example, when Mother told the community midwife about her previous children the midwives escalated their concerns to children's social care. This led to the formulation of a pre-birth plan and Child F being accommodated at birth. However, there is also evidence that the forensic psychology report was not used to inform later planning when it clearly had information that was relevant to the changed circumstances for Child F.

Was there evidence of professional optimism in this case?

12.8 As discussed in section 10.3, professional over optimism was found to be one of the root causes of this incident.

Is there sufficient evidence to suggest this incident was preventable?

12.9 The author feels that it is unlikely that professionals could have foreseen the exact sequence of events that led to Child F ingesting Tramadol. The sequelae of the child having a respiratory and cardiac arrest were probably inevitable once he had ingested a large dose of opiate and had appropriate emergency intervention for fitting from the ambulance crew.

12.10 Child F had intervention for a number of years from experienced professionals. Although there was an increasing trend of incidents of concern, no one incident met the threshold for intervention. It is possible that a senior manager reviewing the case with the Health Visitor or the Social Worker may have seen that there was potential for the case to be reopened, but it is unlikely that it would have met the threshold for intervention.

What are the root causes that could have prevented this incident happening?

12.11 The root causes of the incident are found to be:

- Practitioners were overly optimistic about the Mother's ability to parent Child F.
- Mother displayed disguised compliance or "faking good".
- Tramadol was readily available in the family home.

What could agencies have done differently?

12.12 There could have been more professional challenge in this case, particularly around the case being said to be closed after the referral from ED and the explanation for the bruising on the child's legs being accepted by the paediatrician. In addition, a fuller picture of Mother's mental health, back pain and use of prescribed medication may have alerted practitioners to the dangers of disguised compliance. More rigorous follow up of requested actions and a periodic review of historical information may also have helped practitioners to see the emerging negative picture.

Did professionals view the case through the eyes of the child?

12.13 As discussed in section 9, there is some evidence of life for Child F being considered, but there was a worrying lack of consideration of his sibling Brother 1.

13 Recommendations

13.1 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.

13.2 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.

13.3 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.

13.4 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
- 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

13.5 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.

13.6 DSCB should consider the status of DARP and how professionals' views are fed into the decision-making processes.

13.7 DSCB should consider the use of Signs of Safety and if it is the preferred model all agencies must have a consistent understanding of its application.

13.8 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.

13.9 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.

14 Appendices

Appendix 1	Membership of Panels
Appendix 2	Sources of information used
Appendix 3	References
Appendix 4	List of Abbreviations

This document was classified as: OFFICIAL

Appendix 1: Membership of the Panels

- County Durham and Darlington NHS Foundation Trust (ED, maternity, urgent care)
- Darlington Borough Council (Children's Social Care, Family Intervention Team/Early Help Service)
- Darlington Clinical Commissioning Group
- Durham Constabulary
- Nursery
- Harrogate and District NHS Foundation Trust (0-19 service)
- NECA – Drug and Alcohol Service
- North East Ambulance Service NHS Foundation Trust
- Primary Care – GP practice

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Appendix 2: Sources of Information Used

Case Review Panel Meeting held 6.12.1.8

Case Review Panel Meeting minutes held 5.9.18

Rapid Review Panel Meeting Notes held 26.7.18

Chronology – DBC Children's Services Social Care

Chronology – Newcastle Upon Tyne Hospitals

Chronology – Harrogate and District NHS Foundation Trust (0-19 Service)

Chronology – North East Ambulance Service NHS Foundation Trust

Chronology – County Durham and Darlington NHS Foundation Trust (Maternity, ED and urgent care centre)

Chronology – Primary Care (GP)

Chronology – Durham Constabulary

Medical Report RVI in relation to Child F

Forensic Psychology report dated 8.4.15

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Appendix 4: List of Abbreviations

CDDFT	County Durham and Darlington NHS Foundation Trust
DARP	Darlington Allocation and Resource Panel
DBC	Darlington Borough Council
DMH	Darlington Memorial Hospital
DSCB	Darlington Safeguarding Children Board
ED	Emergency Department
EYP	Early Years Practitioner
GP	General Practitioner
HDFT	Harrogate and District NHS Foundation Trust
HV	Health Visitor (now part of the 0-19 service)
NECA	North East Council on Addiction (Drug and alcohol service for Darlington)
NEAS	North East Ambulance Service
RCA	Root Cause Analysis
RVI	Royal Victoria Infirmary (Newcastle upon Tyne)
SCBU	Special Care Baby Unit
SCR	Serious Case Review