

**EXECUTIVE SUMMARY
OF THE OVERVIEW REPORT
FROM THE SERIOUS CASE REVIEW
ON ADAM**

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on behalf of Haringey's
ACPC.

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INTRODUCTION

1. This is the Executive Summary to the Overview Report of the Serious Case Review concerning Adam. Names given for family members are fictitious.
2. The circumstances of Adam's injury and the reason for the Serious Case Review are as follows:
3. On 17 February 2003, the London Ambulance Service was called by Adam's mother. Adam, aged two and a half years, was rushed, accompanied by his mother, to the Whittington Hospital with serious burns to both his shoulders and the left side of his face and head. The Whittington Accident and Emergency Department performed emergency care and transferred him to the specialist Burns Unit at Mount Vernon Hospital as his burns were deemed to be too serious for the Whittington to deal with as they covered 28% of his body. His condition was serious but fortunately he made excellent progress and was discharged on 4 March 2003.
4. Adam has a twin sister, Leila. She was present on the night of the burn and it is believed accompanied him to the hospital together with their mother. Both children had been in the care of their mother, Julia. Julia stated to the London Ambulance Service that she had been boiling a kettle in the kitchen. She had heard a cry and had found Adam on the floor with a wet T-shirt and the kettle empty by his side. She had put him in a bath of cold water and called the ambulance service.
5. On 20 February 2003 the Health Visitor alerted the Social Services Department (SSD) to Adam's burn. She had gained the information from a Community Psychiatric Nurse who, in turn, was informed of it by Adam's father, Ahmed. A child protection investigation resulted.

BACKGROUND TO THE REVIEW

6. In order to complete the Overview Report Haringey ACPC set up an Overview Panel. The Panel members were:

Renuka Jeyarajah-Dent (Chair)	Director of NCH-The Bridge Child Care Development Service, Teacher and Educational Psychologist
Dr Brian Douglas	Consultant Psychiatrist and Adult Mental Health lead on Haringey ACPC; Barnet, Enfield and Haringey Mental Health NHS Trust
D.I. David Byford	Murder Review Group, Critical Incident Review Team, Woodford Police Station
Dorian Cole	Nurse Consultant and Designated Nurse, Haringey Teaching Primary Care Trust
Jenny Reid	Designated Child Protection Nurse, Hillingdon Primary Care Trust
Teresa Walsh-Jones	Social Worker and Service Manager, Child Protection & Planning Unit, Haringey Social Services Department

7. In addition The Bridge obtained legal advice from Mhairi McNab, Barrister.
8. The Bridge has an established and respected reputation for undertaking Serious Case Reviews. The Executive Summary is limited to conclusions and recommendations in keeping with legal advice.
9. The chronological information analysed dated from 15 October 1991 until 4 March 2003 when Adam was discharged from the specialist burns ward of Mount Vernon Hospital.
10. Individual Management Reviews (IMRs) were obtained from:
 - Haringey Social Services Department from 25 November 2002
 - Haringey Teaching Primary Care Trust from 15 October 1991
 - Barnet, Enfield and Haringey Mental Health NHS Trust from 18 November 2002
 - The Metropolitan Police Service from 6 January 2002
 - EPIC from 19 November 2002
 - West Hertfordshire Hospital NHS Trust from 18 February 2003
11. In addition, interviews were undertaken with a general practitioner (GP), consultant surgeon and a police officer involved in the case.
12. The purpose and terms of reference of the Serious Case Review were as is defined in 'Working Together', Chapter 8¹. The intention is to learn from this case in order to improve inter-agency working and better safeguard children by formulating an action plan based on the conclusions and recommendations.
13. This Serious Case Review considered the information that was known to the multi-agency system before the burn and how it was shared and assessed in relation to ensuring adequate parenting of the twins. It also considered the inter-agency work in the time Adam was in hospital with the burn until his discharge on 4 March 2003.
14. The Overview Report was a detailed document including a chronology of the mother's mental health history as an adolescent. A literature review, 'Mental Health and Parenting: Somatoform Disorders' completed by Dr P. Moran, provided help to the Panel in understanding the mother's symptoms, considered under the rubric 'somatisation'.

¹ Department of Health, Home Office & Department for Education and Employment, 1999, *Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children*. London: Stationery Office

LESSONS TO BE LEARNED

15. This Serious Case Review concerns a two-year-old boy, Adam who sustained a serious water burn. A child protection investigation has deemed this to be an accident.
16. His young mother was known to have suffered from mental health problems in adolescence. She did not attend school in the last two years of statutory schooling probably because of emotional problems. Education records were not available.
17. Her medical history indicated that these problems re-emerged and intensified after the birth of Adam and his twin - especially after their second birthday. Her problems were presented to health services as both physical and emotional symptoms and were variously called Myalgic Encephalitis (ME) and Chronic Fatigue Syndrome (CFS). She was assessed by emergency *adult mental health* hospital services for the first time when Adam was 2 years old and in the following weeks was seen by members of a local community mental health team and hospital mental health doctor. Just over two months before the burn she was admitted to a specialist mental health hospital and diagnosed with a major depressive disorder with psychotic features, including the belief that the children were ill. She discharged herself from hospital against medical advice and was referred to community psychiatric services.
18. When Adam was 10 months he was referred to the SSD after he attended a local A&E department with a blistering radiator burn. In his second year he ingested half a tablet of paracetamol and was taken to the A&E. When he was in his second year, both he and his sister were referred to the SSD for a child protection concern as they were admitted to a local hospital's children's ward as their mother was concerned that they were ill, although there was no medical evidence.
19. Adam's mother's health records related to at least two GP practices - the second becoming involved in Adam's second year. Both The GP practices held information about her emotional vulnerability. The first practice was aware of the threat of deportation relating to Adam's father, inadequate housing and had alerting information of domestic violence. The second practice had information of alleged domestic violence against father from mother. GP files did not transfer until after Adam's burn.
20. The GP practice, SSD and health visiting service believed that Adam's father, especially in Adam's second year, provided his primary care and that the extended family was supportive.
21. This section summarises conclusions and recommendations from the Overview Report.

The Mother's Early Mental Health

22. There is evidence that Adam's mother was referred to a local Child and Adolescence Mental Health Service. She was offered an appointment 10 months later, despite school refusal. Records do not indicate that this service sought permission to obtain or did not obtain contextual information from school or family.
23. (Recommendations made here relate to mother's history and not to Adam who is the subject of this Serious Case Review).
24. The Overview Panel recommend that Barnet, Enfield and Haringey NHS Mental Health Trust ensure that:
 - Child and Adolescent Mental Health Service (CAMHS) referral forms are designed to collect information which will describe risk and thus help to prioritise the children on the waiting list, including school non-attenders
 - audit of CAMHS case files confirm that individual clinicians actively seek information from other agencies to add to their own clinical perspective when concerned about risk

Issues Relating to GP Communication With Other Agencies

25. The GP recorded Adam's mother's emotional vulnerability. On the day of his birth the GP listed historical stressors that may have added to this vulnerability. The GP also had evidence that Adam's mother was ambivalent about the pregnancy. There was no evidence on GP records that this was relayed to the obstetric service at North Middlesex Hospital. This is essential if alerting information in relation to a mother's emotional vulnerability/capacity to parent is to be analysed by this service.
26. The Overview Panel recommend that the Hospital Trusts responsible for Obstetric Services:
 - encourage GPs, on referral to antenatal clinics, to routinely include risk factors in relation to mothers and unborn children by considering the use of pre-designed referral forms to indicate the range of information required
 - review their assessment process to ensure that the Health Visiting Service is alerted to risk
27. The Overview Panel also recommend that HTPCT encourage, through training:
 - GPs to summarise the risk factors to mother and baby on referral to ante-natal clinics

28. The GP did not alert the health visitor to this family's potential vulnerability at the birth of the children. Neither GP or health visitor records indicated that there was any communication between these two agencies despite growing concern on the part of the GPs about Adam's mother's mental health. The Overview Panel concluded that there was information that both GPs should have communicated to the health visitors. This might have led to the family being prioritised for health visitor intervention/support and joint analysis of whether the family's needs crossed the threshold for a referral from health to the SSD.
29. In the case of the second GP practice, the Overview Panel concluded that events after Adam's second birthday relating to his mother's mental health necessitated referral/communication with the SSD. This was especially after concern for her intensified and after the A&E had referred to the SSD because of concern relating to Adam's mother's mental health and impact on her parenting.
30. The Overview Panel recommend that HTPCT encourages through:
 - training that all GPs are aware of their duties under *Working Together* and liaise with other relevant professionals in order to ensure the protection and well being of children.
 - audit of files that there is evidence to show that GPs are referring children on to the SSD and health visiting service at the appropriate thresholds and responding to requests for information about children and their families from other agencies appropriately.
31. And in addition that HTPCT consider:
 - how to encourage GPs and health visitors to allocate time and resources for formal joint case discussion.

A Good Enough Assessment

32. The Framework for the Assessment of Children in Need and their Families (DoH, DfEE and The Home Office, 2000) states that a good assessment has to include information about the child, the carer and the context in which they live. *Working Together 1999* states that safe guarding children depends "crucially upon effective information sharing, collaboration and understanding between agencies and professionals".
33. Appropriate communication between professionals is crucial for good assessment and this has been addressed above in relation to the GP, mental health and health visiting services and the SSD.
34. A good assessment necessitates each discipline adding particular expertise to the process. In this case the social worker and the health visitor did not add to the information already known with their own assessment when Adam was referred to the SSD after the radiator burn and his first admission to hospital and also during

the child protection investigation. The health visitor should have collected and recorded child development information at least at one of these points and the social worker information about contextual and family functioning. Their records indicated that their involvement only resulted in the collection of information already available.

35. The Overview Panel therefore recommend that the SSD ensure that:

- supervision protocols ensure that assessments are completed
- file audits ensure consistency in assessments and include answers to some standardised questions about safety and protection

36. The Overview Panel also recommend that HTPCT through training and file audit that:

- health visitors understand their role in a child protection inquiry and their added value in relation to an assessment.

37. History is the best predictor of need/risk. Appropriate historical information did not join referrals from the GP to adult mental health services nor was it considered fully by the SSD when referrals were made to them.

38. The Overview Panel, therefore, recommend that Haringey ACPC:

- encourage all agencies to make use of chronologies which include all relevant history and progress of the case

39. And that Haringey ACPC review:

- information available to professionals in relation to their duties regarding confidentiality with reference to recent national guidelines; for example, 'Confidentiality: NHS Code of Practice' (DoH, 2003); 'What To Do if You Are Worried a Child is Being Abused' (DoH, DfES, HO, 2003) and 'National Service Framework for Children: Emerging Findings' (DoH 2003).

More detail regarding confidentiality is expected as Information Sharing and Assessment (ISA) pilot sites report and government guidelines emerge with legislation relating to the Children's Bill.

40. In this case it was accepted that Adam's father, with the support of extended family was providing the practicalities of the care required by the children, although mother was at home and the primary carer. Contextual issues like housing and income were not recorded as being considered and there was no validation of appropriate child development. The GP did not provide written information to child protection strategy meetings. Information given and gathered from the GP was not adequately evidenced in records.

41. The Overview Panel recommend that Haringey ACPC review child protection training to ensure that:
- information collected directly is always used when assessing the child's development. (In this case the HV should have been asked to carry out a developmental assessment before the initial assessment was concluded.)
 - families should be asked to describe in detail the practicalities of the care of the children - especially in cases such as this where it is clear that the primary carer is unable to perform this task adequately.
 - contextual issues, like the housing and income available to the family, should be addressed as this allows insight into the presence of other stressors.
 - the GP's information should be actively sought in all cases but especially when it is clear from the information available to all agencies in this case that it was this agency that would hold the most information about the family - especially in relation to history.
42. Record keeping is an essential to good on-going assessment. In this case there were examples of poor record keeping, including details of referral information from the GP to other agencies, minute taking at referral meetings relating to the Community Mental Health Team, minute taking at child protection strategy meetings, recording and filing of assessment information by the SSD.
43. The Overview Panel recommend that Barnet, Enfield and Haringey Mental Health NHS Trust ensure that:
- decision making and required actions are recorded and monitored
44. The Overview Panel recommend that Haringey ACPC review:
- administrative systems are in place for the clear and concise recording of those meetings crucial to child protection.
45. In addition the SSD's notes were particularly sparse and the Overview Panel recommend that the SSD ensure that:
- the quality of record keeping is of the required standard through out the department.

Mental Health and Its Impact on Parenting

46. The main feature in this case was the impact of Adam's mother's mental health on the care provided to the children. A diagnosis of a mental health illness was not made until just over two months prior to the water burn. However, the effect of this

and her prior behaviour was not appropriately considered by any of the agencies involved in relation to care of the children. In fact risk assessment forms were either wrongly filled in by adult mental health or not filled in at all, therefore not enabling the children to be kept at the forefront of interventions. The Overview Panel also noted that 'having children' is not a factor considered in 'eligibility criteria' for adult mental health services (CMHT).

47. In this case the GP was concerned about the risks to the children and disagreed with the CMHT about this at one point. Therefore the case should have been further discussed with other senior mental health professionals (and the SW and HV). The Overview Panel noted that the GP could have requested a domiciliary visit by a psychiatrist.
48. The Overview Panel recommend that Barnet, Enfield and Haringey NHS Mental health Trust ensure that:
- mental health service workers complete risk assessment forms and when appropriate these are distributed to key child protection agencies
 - in cases where professionals disagree about the risks posed to children, a strategy to resolve this must be pursued involving relevant agencies
 - in cases of ongoing contact by adult mental health services, one professional in the team is allocated to review regularly the impact of parental behaviour on the children.
 - The eligibility criteria are reviewed in order to prioritise patients caring for non-school going children.

49. The Overview Panel recommend that:

Haringey ACPC and BEHMHT:

- set up an inter-disciplinary working group to review and develop policies and practice guidance to enhance individual agency casework and inter-agency communication in relation to parents with mental health problems. The group should audit case files to form a view on current practice in order to set relevant targets. The purpose of the work should be to:
 - i. enable professionals to keep children central even when concerns are in relation to adult mental health.
 - ii. put systems in place for efficient inter-agency communication.
 - iii. arrange for social workers to obtain swift advice from mental health specialists for the most serious cases.

- iv. arrange for this advice also to be in relation to discussing the reality of future care for children in the absence of a diagnosis but where there is concern about parental behaviour.
- v. provide appropriate inter-agency training on the essential needs of children and consider how parenting is affected by mental ill health.

The Child Protection Investigation

50. The investigation was difficult because of the complexity of the mother's needs and the range of organisations involved. Staff at the burns unit believed that the parents and they themselves were not being kept appropriately informed of the process and shared this view with the family. Police records noted their contact with the parents starting at the beginning of the process. The SSD records did not evidence face-to-face contact with parents until 8 days into the investigation. There was limited time spent with the children by any of the professionals other than ward staff. There was also limited involvement of the GP who held considerable knowledge about the family.
51. The Overview Panel recommend that:

Haringey ACPC review protocols to include that:

- police and SSD agree the information that is to be made available to other agencies in relation to the reasons for a child protection referral
- consideration is given to establishing what information is given to parents in relation to a child protection referral and investigation and the procedure for determining which agency will be responsible for communicating this to parents
- particularly in cases where Fabricated Induced Illness Syndrome or similar is suspected the medical services are kept informed and their discussion actively sought
- a system is in place to discuss inter-agency dispute regarding individual cases

West Hertfordshire Hospital NHS Trust ensure that:

- staff are made aware of their obligations under *Working Together* (1999) and the role of the named nurse and doctor for child protection.

Miscellaneous

52. Adam's mother had had contact with several local hospitals and Adam was seen by local A&E departments on at least three different occasions. An A&E attendance slip

did not reach the health visitor until one week after his hot water burn and this was after a reminder. Recommendations have been made relating to hospitals under other headings but the following are additional.

53. The Overview Panel recommend that Whittington Hospital Trust and Haringey Teaching PCT ensure that:
 - all relevant professionals are aware of their responsibility to alert the health visitor (or school nurse if in school) and/or GP, especially after admissions to hospital or casualty departments.
54. Adam's sister received very little attention from professionals during the period covered by the case review.
55. The Panel therefore recommend that the ACPC through training and review of procedures ensure that:
 - professionals are made aware of their duties under *Working Together* (1999) to all children in the family when there is concern for one child in the family
56. The quality of information provided to the SSD by other agencies, particularly during the child protection investigation, was in general lacking in detail.
57. The Overview Panel therefore recommend that Haringey ACPC review procedures to consider:
 - the use of pro formas to guide professionals in considering what information to provide.
58. Victims of burns tend to be vulnerable people. The impact of a serious burn on emotional well being can be great. The specialist unit did not receive adequate historical or contextual information about Adam.
59. The Overview Panel recommend that Whittington NHS Trust ensure that:
 - in events where injury to a child is serious A&E staff consider risk by checking the Child Protection Register, collating past and current information and passing this to the specialist service
60. The Overview Panel also recommend that West Hertfordshire Hospital NHS Trust/Mount Vernon Burns Unit:
 - make representations to The National Burns Care Review about the need to ensure that information from referring hospitals includes historic/background information about children so that the child's welfare and protection can remain paramount. Such information may

have to join the case notes soon after the crisis event when the referrers have had an opportunity to reflect.

61. The Overview Panel were surprised at the lack of specialist emotional support for child victims and their families after suffering the trauma of a burn. They therefore recommend that West Hertfordshire Hospital NHS Trust consider:
 - resources which could provide emotional support for patients and their families during a stay in the Burns unit and after discharge
62. EPIC, the SSD and the GP tried to refer Adam's mother to different agencies providing mental health support.
63. The Overview Panel recommend that Haringey ACPC encourage through training:
 - agencies to refer to specialist facilities through professionals in similar fields who have already been involved. (In a time of scarce resources this makes for more efficient service delivery as services more specific to the clients' needs can then be sought and background assessments sent with the referral.)
64. Health visitors are required to prioritise families from their caseload for intervention. In this case knowledge of Adam's mother's mental health needs did not increase recorded interventions from this service.
65. The Overview Panel recommend that Haringey Teaching Primary Care Trust ensure that:
 - the Health Visiting Service audit a sample of cases featuring parents with mental health concerns *and*
 - prioritisation procedure is reviewed to take account of the service specification requirements of mothers with needs as highlighted in this case
66. EPIC attempted to meet with and liaise with the family and other professionals on several occasions and this included on two occasions after the water burn and commencement of the child protection investigation.
67. The Overview Panel recommend that Haringey ACPC:
 - confirm that opportunities for regular supervision in relation to Child Protection is available for agencies like EPIC where, almost by definition, information is being collected about vulnerable children and families.

End Comments

68. This review has shown how good inter-agency communication and analysis is important for the children of extremely vulnerable mothers. Appropriate communication requires not only an understanding of the information alerting of potential concern for children but also the time and professional relationships necessary to reflect together.
69. This review highlights how assessing the children's needs is complicated by the style of mother's presentation. She had multiple and changing symptoms and was in contact with several agencies. Keeping the children's needs central means that one professional prioritises the children during each of the mother's presentations, collecting past information and reflecting with those agencies concerned about the family. Fewer agencies having more contact with the family and time for reflecting together potentially enables more change than a variety of agencies working in an uncoordinated manner.

Renuka Jeyarajah Dent
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