Derby Safeguarding Children Board

Background Information and Summary of SCR DD12

Derby Safeguarding Children Board publishes the serious case review report into the tragic death in 2012 of a baby boy, known for the purpose of the review as DD12. He was born with very complex medical needs and during his short life he had significant levels of support from a wide range of professionals including health and children's social care.

In February 2012, concerns about his safety were considered by the Family Proceedings Court following an application for an Emergency Protection Order (EPO). The EPO was not granted and the Court determined that the injury being considered was accidental. DD12 returned home. Shortly after this, in May 2012, DD12 died as a result of internal bleeding caused by a head injury. His father pleaded guilty and was convicted of his manslaughter in 2013.

The aim of the serious case review into this case is not to investigate the incident that occurred in 2012 that led to his tragic death as this has been concluded by legal process, but to examine closely the work of individual agencies and their inter-agency process.

The complexities of this case are unusual and have identified improvements for all agencies involved and the Family Proceedings Court, both locally and nationally.

Early Help

Mother's pregnancy with DD12 was relatively uneventful. To the maternity services she appeared to require some additional support primarily because she had experienced a cot death of her first child.

DD12 had serious and life threatening health problems from birth. His parents responded appropriately to these needs and DD12 was seen on a very regular basis by a large number of professionals. The review recognises that because of the complexity of his needs, a lead professional could have been identified to help the mother and father co-ordinate care and communicates with professionals.

Responding to Child Protection Concerns

There was no indication that DD12 might be a child in need of protection until February 2012 when bruising to his penis was first noted. It was this incident that first brought DD12 to the attention of children's social care.

The review finds that the agencies involved responded appropriately. There were some areas where practice could have been better such as contacting the GP as part of the collation of multi-agency information and clearer planning as part of the strategy meeting.

Court Action

Following initial investigation, there was no suitable explanation for the injury to DD12 and children's social care wanted DD12 to be cared for by a foster carer on a temporary basis whilst a detailed assessment of the situation was carried out. The parents were unwilling to allow this to happen and a suitable family member was not available.

The Local Authority therefore applied to the Family Court for an Emergency Protection Order (EPO) because they were so concerned that urgent action should be taken to make sure he was safe.

The Magistrates considered the information presented to them in Court and decided that the grounds for an Emergency Protection Order were not met. The lawyers for the parents asked the Magistrates to determine whether or not the injury had been caused accidentally.

This circumstance was exceptional and it is very unusual for Magistrates to make a "finding of fact" with regards to an injury at an EPO hearing as the amount of evidence and time needed to determine a "fact" is not usually available at such a hearing.

The Magistrates decided to weigh up the conflicting views about the cause of the bruising to DD12 and determined that, on the balance of probability, the injury was caused accidentally.

The Magistrates' legal adviser should have made it clear to the Magistrates that whilst the parent's legal representative asked that they should determine whether the injury was accidental or not, their considerations should have focussed on whether or not an EPO was appropriate.

The lawyers in the court did not assist the Magistrates in addressing the issues which were relevant to deciding whether to grant the EPO application.

The Magistrates believed that the bruising was accidental; the relevant professionals in the case continued to believe the opposite.

It is not possible to establish to what extent the "finding of fact" prevented immediate and decisive actions being taken to establish a plan to protect DD12 but it did appear to disempower professionals.

The review finds that there should have been a debriefing meeting of all professionals involved in his care where the legal ramifications of the finding could have been explained. Furthermore this meeting could have defined a high level and

vigilant child in need plan and ensured that this was put in place. The finding of fact appeared to undermine professional scepticism.

Work with the family after the Court hearing

DD12 returned home to live with his parents at the end of February. Professionals continued to visit him at home focussing on his health needs. As a result of the "finding of fact", new professionals who began working with the family were not always aware of the previous concerns.

It is likely that had this been known and part of a more robust plan, the monitoring of DD12 would have focussed not only on his health needs but also his safeguarding needs in the context of what was known about his history and vulnerability.

This is not to say that monitoring was not taking place, indeed DD12 was regularly seen by professionals between the end of the court case and his death.

On 8th May an emergency telephone call was made by DD12's father claiming that DD12 was having a fit. He was admitted to hospital and died the next day. He had serious internal head injuries. DD12's father pleaded guilty to manslaughter.

Summary

DD12's complex needs were being met by a number of health providers working together and the case has emphasised the need to provide coordinated early help across all children with disability services where families are experiencing difficulties.

Once a suspicious injury had been identified, decisive action was taken by all agencies. More robust advice to the Magistrates should have been provided and the impact of the decision by the Magistrates that this injury was definitely accidental was significant. It left professionals unsure how to work with the family and whether there were ongoing child protection concerns.

Despite this DD12 was seen regularly by trained professionals who did not see significant indicators of concern.

Serious case reviews often identify lessons that have been learnt before but this one is unusual. The review does not identify major failings in respect of agencies working together; it identifies features of good practice. However, there are lessons about ways in which professionals felt tied by decisions. He was not an invisible child, but one who was well known to local agencies during his short life and action was taken to try to protect him.

Action has been taken on all the recommendations arising from the review, eight of the recommendations have been completed and signed off, whilst significant progress has been made to complete the other recommendations.

Her Majesty's Courts and Tribunal Service (HMCTS) have assured the Board that specific advice was issued to all legal advisors on the management of any application for an emergency protection order; all such applications are now referred to the senior family lawyer on site to ensure appropriate supervision. The outcome of emergency protection order proceedings are now reviewed to check that lawyers act

in accordance with High Court guidance and in all such future applications Magistrates will, wherever possible, be advised by a member of a local specialist team of family lawyers. HMCTS is confirming that procedures at all courts dealing with emergency applications of this type are fully compliant with the current rules. The creation of a Single Family Court will also mean that in future such applications can now be considered by judges as well as by Magistrates.

In light of this case, there is careful reflection when Emergency Protection Orders are sought when there is no safe alternative and to ensure that there is sufficient evidence to support the application.

24/04/2014