EXECUTIVE SUMMARY OF REPORT
OF
BLACKBURN WITH DARWEN
LOCAL SAFEGUARDING CHIDREN BOARD
UNDER PART 8 OF
"WORKING TOGETHER"
INTO THE DEATH OF
NP

June 2008

In respect of:

NP

Contents Page

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Reason for Review

In January, 2004 NP aged 8 weeks was taken to hospital by his mother RP with breathing difficulties, having been discharged home from the neo natal unit two weeks earlier. He was found to have excessive amounts of paracetamol in urine and blood samples. It was concluded this had resulted from the excessive administration of paracetamol based medication. During the care proceedings which followed it became known that medication had been administered by NPs mother, who was subsequently convicted of child cruelty.

NP survived the paracetamol poisoning, however he was left blind with severe brain damage and suffered from frequent epileptic seizures.

NP was discharged from hospital in February, 2004 and placed with Foster Carers. He subsequently underwent several operations and was regularly seen by consultants at different hospitals. Despite the excellent care provided by his Foster Carers he stopped breathing in March, 2007 and sadly, was pronounced dead on arrival at hospital.

Terms of Reference for the Review

On 27th March, 2007 the Serious Case Review Group of the Safeguarding Children Board met to make a recommendation as to whether a Serious Case Review should be held in respect of NP. The recommendation that it was appropriate to hold a review was subsequently accepted by the chair of the Local Safeguarding Children Board (LSCB).

The Serious Case Review Group met on 21st May, 2007 and the following Terms of Reference were agreed:

- To answer the questions set out at paragraph 8.27 of Working Together to Safeguard Children 2006 and prepare an analysis of agency involvement and the conclusions and recommendations made as a result of the lessons to be learned from this case.

- The Review would be concerned only with the events preceding NP's hospital admission, since this was the period during which the actions of the agencies concerned required analysis and during which any lessons to be learned would be identified.

- However information would be presented which may help to address the question of RP's mental health state since this would be a key area requiring consideration.

Contributors to the Review

In compiling this review the panel have had the benefit of reports from:

1. Blackburn with Darwen PCT whose review encompassed Lancashire Care Trust, East Lancashire NHS Hospital trust and Blackburn with Darwen Health Economy

2. Lancashire Constabulary

3. Blackburn with Darwen Integrated Children's Services

4. Blackburn with Darwen Borough Council's Legal Department

We would like to thank the representatives of the agencies concerned for their prompt attention to the task and to ES of Blackburn with Darwen Children's Services for undertaking the difficult task of collating the agency chronologies.

Members of the Review panel

- Mr Allan Buckley, Independent Chair
- Ms Lynne Pickles, Service Manager, Review and Protection Integrated Children's Service
- Ms Jane Carwardine, Designated Nurse for Child Protection
- Ms Kath Thomson, Named Nurse for Child Protection
- Dr Angela Parry, Named Doctor for Child Protection
- Ms Janie Berry, Senior Solicitor, Legal & Democratic Services
- Mr John Daly, Head of Operations, Children's Service's Department
- Mr Paul Lee, District Manager, Lancashire Probation Service
- Ms Anne Munro, Senior Probation Officer
- DI Geoff Hurst, Central Divisional Intelligence Unit

In addition the following took part in the initial meeting of the Serious Case Review panel which recommended that a Review should be undertaken:

- Ms Lynne Pickles, Service Manager, Children's Services Department
- DS Andy Hulme, Public Protection Unit
- Mr John Daly, Head of Operations, Children's Services Department
- Ms Janie Berry, Senior Solicitor, Legal & Democratic Services
- Ms Dorothy Mitchell, Head Teacher, Broadlands Virtual School
- Dr Angela Parry, Named Doctor for Child Protection
- Mr Paul Lee, District Manager, Lancashire Probation Service
- Ms Jill France, Area Children's Services Manager, NSPCC
- Ms Kath Thomson, Named Nurse for Child Protection
- Mr Dave McKee, Service Manager, CAFCASS

Introduction

Professional Involvement within Blackburn with Darwen

The following LSCB constituent agencies and professionals had involvement with or in relation to NP during the period prior to his serious injuries.

Health

- General Practitioner
- Midwifery Service
- Doctors
- Health Visitor
- Physiotherapist
- Consultant Orthopaedic Surgeon
- Dentist

Professional involvement immediately following NP receiving his injuries was with:

Blackburn with Darwen Social Services/Children's Services

Social workers - Blackburn with Darwen Emergency Duty Team Children's Services Social Care.

Police

Hospital staff

Background information

MP Snr was born in Blackburn and his wife RP came to the UK from India to marry him in 1997. A child, MP, was born to the couple by Caesarean section in February, 1999 and following the birth the parents and their child resided with paternal grandparents for approximately 3 months before returning to their own home. Seven months later RP made it clear to health professionals that at that time she had no wish for any more children.

By early 2001, RP was complaining of lower back pain and saw a consultant surgeon in this respect. During June 2002 RP again made it clear to health professionals that she did not want another child. A year later RP's pregnancy had been confirmed and by November 2003 MP Snr, RP and their eldest child had moved to the home of paternal grandparents whilst their own home was being renovated. The living accommodation was very small. NP was born prematurely at 31 weeks and admitted to the neo natal unit. NP was discharged home from hospital on 19.12.03. During the time NP had been in

the neo natal unit there were no indications of difficulties and he was visited by his mother twice a day following her own discharge from hospital. Primary visits by Health Visitor noted that RP had good support from her husband and family.

When aged 8 weeks NP was taken to hospital by the mother with breathing difficulties, having been discharged home from the neo natal unit two weeks earlier. NP was found to have excessive amounts of paracetamol in urine and blood samples. It was concluded this had resulted from the excessive administration of paracetamol based medication. During the care proceedings which followed it became known that medication had been administered by NP's mother, who was subsequently convicted of child cruelty. NP survived the paracetamol poisoning, however NP was left blind with severe brain damage and suffered from frequent epileptic seizures.

NP was discharged from hospital on 4th February, 2004 and placed with Foster Carers. NP subsequently underwent several operations and was regularly seen by consultants at different hospitals. Despite the excellent care provided by the foster carers NP stopped breathing in March, 2007 and sadly, was pronounced dead on arrival at hospital.

Conclusions

We found no serious shortcomings on the part of the agencies involved either individually or collectively. Nor could we identify any areas where it was clear that different decisions or actions might have led to a different course of events. No conclusions could be drawn regarding RP's mental health state either prior to or at the time the medications was administered. Additionally, the panel found that following NP's admission to hospital the response of all the agencies involved represented good practice.

However the Internal Management Review of the Health agencies and the Police identified areas that they would wish to make recommendations about.

Health reported they had found:

- Their assessment records did not clearly identify whether there may have been any barriers to communication or understanding.
- That NP's mother was allowed to stay only one night with NP for "rooming in" prior to his discharge from the neo natal unit following NP's birth. It is noted that whilst there was no record of any indicators to raise concern, the health records do not clarify whether mother's attachment was adequately assessed or not and that this is of particular importance for infants and mothers who are separated at birth and at risk of developing attachment difficulties.
- Health records appeared unclear in respect of the level of support RP was receiving from her family, particularly in relation to the fact she had made it very clear on two occasions to medical staff that she was extremely unhappy at those times about the prospect of having another child.
- Evidence there was some confusion in respect of verbal communication between neonatal intensive care and the Health Visiting Service in respect of NP's discharge from hospital following NP's birth.
- Health records were described as generally satisfactory however they did not meet record keeping standards.
- Health records did not contain any reference to mental health issues, nor do they provide evidence of post natal depression screening.

Blackburn with Darwen PCT contributed to the development of care pathway in respect of screening for post natal depression during 2000-2001. Yet it is not clear from the records whether this was applied consistently in practice following the birth of MP or NP.

- Despite it being essential for health professionals to provide clear instructions in respect of the use of paracetamol with young babies. There is no record whether this explanation was offered although it is always contained on the medication instructions.

As previously stated there was nothing to indicate that any of the above issues contributed to the child's injuries

The Police review concerned the period following NP's injuries and as such any recommendations would not relate to prevention of such events reoccurring. However, the processes the police had been involved in since the child's injuries lead them to recommend that:

- The police develop systems which allow cases to be maintained on either a paper system or a computerised system such as Caseman, to provide an audit facility and to manage individual actions.

All agencies agree to develop and sign a media protocol, whereby the agency with primacy for an investigation should deal with all media matters, involving partner agencies where appropriate. This protocol should then be disseminated to all staff.

Individual Agency Recommendations

From Blackburn and Darwen PCT

1. A record keeping audit should be conducted and BWD PCT should reinforce that all health agencies in local Health Economy ensure they follow Policy & Procedures regarding the clarity of record keeping and signatures

Action: Health agencies

2. Implementation of a post natal care pathway to all women

Action: Health agencies

3. Review of practice regarding the assessment of mother/child attachment

Action: Health agencies

4. Review of clinical practice in respect of language barriers

Action: Health agencies

5. A health promotion campaign regarding the administration of paracetamol to young children

Action: Health agencies

6. A review of paediatric liaison

Action: East Lancashire Health Trust and Blackburn with Darwen Primary Care Trust

7. Review of practice regarding “rooming in” prior to discharge

Action: East Lancashire Health Care Trust

Police

1. In the future cases should be maintained on either a paper system or a computerised system such as Caseman, to provide an audit facility and to manage individual actions

Action: Police agencies

All agencies

1. Consideration to be given to development of an inter-agency media protocol.

Action: All agencies