



# **Bexley Local Safeguarding Children Board**

## **EXECUTIVE SUMMARY**

### **SERIOUS CASE REVIEW**

#### **‘CHILD A’**

**18 MAY 2010**

# 1 INTRODUCTION

## 1.1 CHILD'S DEATH AND RECENT INVOLVEMENT OF LOCAL AGENCIES

- 1.1.1 On Monday 29 December 2008, an ambulance was called to the family home by the mother (referred to as Ms J) of a White British boy then aged 21 months and referred to as child A.
- 1.1.2 Ms J reported her child was 'dead' and 'cold'. Resuscitation was attempted by the ambulance crew who had arrived within minutes and continued at the hospital to which the child was rushed (referred to in this summary as hospital 2). Child A was pronounced dead at 9.54am at hospital 2.
- 1.1.3 Post mortem examinations concluded that child A died as a result either of internal or head injuries, either or both sufficiently serious to be fatal and both inflicted by another person or persons. The injuries had been sustained over the previous 48 hours although the head injury was likely to have happened the night before his death.
- 1.1.4 Child A's mother and her then partner (referred to in this report as Mr D) were arrested later that day at the hospital. They faced criminal charges in relation to the death of child A. Ms J was convicted of child A's murder on 14 May 2010 and Mr D was acquitted of all charges.
- 1.1.5 On 8<sup>th</sup> December 2008, child A was admitted to hospital 1 with a fracture to his leg and bruising. He was treated, a number of checks were made and he was sent home the next day.
- 1.1.6 The injuries observed by hospital staff at the time of attendance at hospital 1 had initially been regarded with suspicion but, following further medical examination, non accidental injury was ruled out and no referral was made either to Children's Social Care or the Police.
- 1.1.7 Prior to his presentation to these hospitals, child A was known to universal services such as the GP, health visiting and parent and child clinics. These services had not identified any cause for concern.
- 1.1.8 The following is an anonymised executive summary of a more extensive report (containing confidential details of family and professionals) arising from a serious case review completed in early July 2009 and contains:
- Reasons for and process followed by those undertaking the review
  - An overview of the involvement of local agencies with child A's family throughout the relevant period
  - Conclusions and lessons to be learnt from this serious case review and

- All the recommendations contained in the full report, which have been accepted in their entirety by relevant agencies and have been implemented
- Inter-agency Action Plan which has been completed.

1.1.9 This summary also reflects the evidence given and the outcome of the trial of Ms J and Mr D in May 2010 which was not known when the serious case review was conducted.

1.1.10 For the purposes of clarity the anonymised family relationships and institutions are outlined below:

Child A Subject of this review

Child B Older child of Ms J and Mr F

Ms J Mother of child A and child B

Mr F Father of child B

Mr E Father of child A

Mr D Ms J's partner at the time of child A's death

Hospital 1 Darent Valley Hospital, Dartford

Hospital 2 Queen Mary's Hospital, Sidcup

## 2 SERIOUS CASE REVIEW PROCESS

### 2.1 INITIATION AND CONDUCT OF REVIEW

2.1.1 When any child dies, and abuse or neglect is known or suspected to be a factor in the death, the law requires Local Safeguarding Children Boards (LSCB) to conduct a 'serious case review' that examines the involvement with child and family, of local organisations and professionals.

2.1.2 The purpose of a serious case review is to:

- 'Establish whether there are lessons to be learned from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children;
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of children'

2.1.3 Bexley's Safeguarding Children Board immediately recognised that child A's death required a serious case review and in early January 2009:

- Convened a serious case review panel with an independent chairman and relevant professionals who had had no direct involvement with services offered to child A or members of his family
- Details of the serious case review panel membership is included in Section 6, Terms of Reference
- Agreed, in consultation with the Government Office for London, what time period should be considered and the specific questions to be addressed by those contributing to the serious case review
- Formalised the focus of the serious case review by 'terms of reference' which (anonymised where necessary) are appended to this summary
- Notified Ofsted, the relevant Government regulator, the role of which in such cases is to evaluate the rigour and effectiveness of serious case reviews.

2.1.4 An independent author was commissioned to write a composite overview report bringing together the facts and analysing the findings of the management reports and chronologies produced by all involved agencies, and provide appropriate challenge. A timetable was established for submission of individual management reviews and consideration of the resulting overview report in July 2009.

2.1.5 The panel met on four occasions and meetings of the respective authors of individual management reviews were convened on three occasions. The overview report writer attended meetings of the Serious Case Review panel and the authors' group.

- 2.1.6 An invitation to contribute to the Serious Case Review was sent to child A's family. His birth father (Mr E) and paternal grandparents were subsequently interviewed and their information, experiences and perspectives are reflected in this report. Ms J's family did not respond to the invitation.
- 2.1.7 The overview report was considered by the Serious Case Review panel on 08 July 2009 and it was formally signed off by the Chairman of the LSCB on behalf of the full Safeguarding Board on 13 July 2009.
- 2.1.8 The serious case review was evaluated by Ofsted as being "Good" on 17<sup>th</sup> November 2009.
- 2.1.9 The Serious Case Review has been reviewed following the outcome of the trial in May 2010 and has been amended in line with 'Working Together' para 8.2.7.

## **2.2 AGENCIES CONTRIBUTING INDIVIDUAL MANAGEMENT REVIEWS**

- 2.2.1 Individual management reviews were provided by the following agencies:
- Dartford & Gravesham NHS Trust (for hospital 1)
  - Bexley Care Trust (GP and health visiting)
  - Queen Mary's Sidcup NHS Trust (for hospital 2) [due to local reorganisation now part of South London Health Care NHS Trust]
  - Metropolitan Police Service (involvement with some relevant parties)
  - London Ambulance Service (emergency response to 999 call)
  - London Borough of Bexley Children's Services in relation to child B
  - A Primary School in Kent in relation to child B
  - Oxleas Foundation NHS Trust (Child and Adolescent Mental Health Services) in relation to child B
- 2.2.2 The post mortem reports noted a large number of injuries, probable timing and likely cause of death. Consequently, an expert medical opinion was sought, for the purposes of advising the Serious Case Review Panel, from Professor Jonathan Sibert OBE MD FRCPCH, Emeritus Professor of Child Health, Cardiff University. Throughout the Court case expert medical opinion was considered by judge and jury and has been reflected in this summary.

## **3 OVERVIEW OF AGENCIES' INVOLVEMENT WITH CHILD A'S FAMILY**

### **3.1 BACKGROUND: THIS SECTION PROVIDES A CHRONOLOGICAL OVERVIEW OF AGENCIES CONTACT WITH THE FAMILY**

#### **Child A's older half-sibling [child B]**

- 3.1.1 Child B was born in 1999. Ms J and Mr F separated when child B was a year old although his father continued to maintain contact with his son initially. Ms J contacted Children's Social Care in 2002 and in 2003 because she alleged historical domestic abuse which she felt was having an impact on child B's wellbeing. Ms J and child B were offered support services through a Family Centre and Women's Aid. This was a voluntary arrangement which Ms J did not sustain beyond initial meetings.
- 3.1.2 Child B was referred to the Child & Adolescent Mental Health Service (CAMHS) in 2003 and 2005 by his GP at the request of Ms J. Child B was prescribed medication for Attention Deficit Hyperactivity Disorder (ADHD) but, again, Ms J's engagement was poor. In 2007, the case was closed to CAMHS and child B was referred back to his GP.
- 3.1.3 Child B attended a local primary school where his attendance was good and there was effective engagement with Ms J. The school did not have concerns about his behaviour. Child B did have additional educational needs and received support for these in school.

#### **Family context at child A's birth and early childhood**

- 3.1.4 When child A was born in March 2007 Ms J was in a relationship with child A's father (Mr E). Mr E, in his contribution to the serious case review, described a stormy relationship between himself and Ms J. However he stated there was no violence between them and he was clear that at the time Ms J was a committed mother who was defensive of her children. At no time during their relationship did he feel that she would harm either of her children. The relationship between Ms J and Mr E ended in October 2008. Mr E maintained contact with child A and child B seeing them three times a week with one overnight stay.
- 3.1.5 A relationship between Ms J and Mr D started about 2 weeks later, although Mr D did not move into the family home he was a regular visitor and stayed 2-3 times a week from the start of the relationship in mid October 2008 until child A's death at the end of December 2008.
- 3.1.6 There was a close family network with all grandparents of child A. The extended family were actively involved in his life, providing regular care and support to both the children and their parents.

## 3.2 CHILD A's PRESENTATIONS TO HOSPITALS

- 3.2.1 In May 2007 at 2 months of age, child A was referred to hospital 1 because of concerns about 'faltering growth'. He was fully assessed and monitored by the hospital and health visiting service over the next 11 months with almost weekly contact. He was weighed and seen regularly at the baby clinic during the first 14 months of his life. During this frequent contact with health professionals, including GP, health visitor, nurses and doctors, no concerns were raised about parenting. In April 2008 child A was discharged by the hospital as his weight gain had improved. The outcome of the medical assessment was that the faltering growth was organic in nature and that it was likely, as both parents (Ms J and Mr E) were of slight build, to be an inherited characteristic.
- 3.2.2 Apart from one incident in December 2007 when child A was taken to hospital by ambulance following an accidental choking incident there is nothing else of note in his history until December 2008.
- 3.2.3 On 8 December 2008 child A was taken to hospital 1's Accident and Emergency Department (A&E) by Ms J and was diagnosed as having a fracture to his right leg. It was also noted that he had bruising to his forehead. Ms J stated that child A had injured his leg the previous day in an unobserved incident. When asked about the bruising to the face Ms J became defensive and said that it was as a result of head banging against his cot.
- 3.2.4 However, A&E staff were concerned that the leg injury may have been a non-accidental injury because of a lack of explanation about the cause of the injury, bruising to the face and delay in seeking medical assistance. Child A was kept in hospital overnight and a full physical examination was conducted as well as a skeletal survey. These examinations revealed no further injuries, bruises or fractures. Telephone checks were undertaken with Children's Social Care on two occasions (once in A&E and once on the ward) to ask if child A was subject to a child protection plan (previously known as the child protection register). The staff involved concluded that the injury was accidental and, therefore, no child protection referral was made.
- 3.2.5 Child A's father (Mr E) told the serious case review panel that, when he visited child A on the ward, he introduced himself as child A's father and asked to speak to a doctor. Mr E said he was not spoken to by relevant staff.
- 3.2.6 Child A was discharged from hospital the next day as it had been concluded the injuries were accidental. There was a delay in notifying the health visitor about his admission to hospital.
- 3.2.7 Over the next three weeks child A and child B spent approximately half of the time staying with child A's father (Mr E) and his parents. Child A returned to his mother's care on the 27 December 2008, two days before his death. Child A's father (Mr E) and his family report that the bruises

seen at the hospital admission had faded and child A had no fresh bruising when he left their care.

- 3.2.8 On 29<sup>th</sup> December 2008 at 9.23am an ambulance was called to the family home at 9.23am by Ms J. Resuscitation was attempted by the ambulance crew and the Police were called en route to A&E at hospital 2.
- 3.2.9 Child A was pronounced dead at 9.54am and it was noted that rigor mortis had set in. Post mortem evidence showed that he had died several hours earlier. Ms J and Mr D were subsequently arrested at the hospital.
- 3.2.10 At A&E (Hospital 2) Ms J reported that: child A had been unwell the previous day, and she had sought advice from her mother who advised she take him to the GP the next day; the following morning, without checking on Child A, she had rung the GP surgery who advised a GP would ring her back; she then went into Child A's bedroom and found him apparently lifeless.

## 4 FINDINGS AND LESSONS LEARNT

### 4.1 THIS SECTION FOCUSES ON THE KEY FINDINGS AND LESSONS LEARNT FROM THIS REVIEW THAT HAVE BEEN TAKEN FORWARD TO IMPROVE SAFEGUARDING PRACTICE

4.1.1 The analysis of the actions taken by agencies show that there were no concerns for the well-being of child A prior to December 2008. Child A's presentation at hospital 1 on 8<sup>th</sup> December 2008 was the first indicator that there may be an issue with the care provided by his mother. The serious case review found that the ferocious and catastrophic events leading to child A's death could neither have been predicted nor prevented. Non-accidental injury was considered during the hospital admission and ruled out, however the procedure for a child protection referral were not fully followed. Detailed analysis of this case identified three key findings.

#### 4.1.2 **Ensuring that the child is kept at the centre of any intervention**

- The child's admission for a fuller assessment is an indicator of good practice. However an holistic assessment sharing of the child and family circumstances was not carried out in this case. The fact that child A was 'not known' to Children's Social Care, coupled with the findings of the medical examinations offered false reassurance and outweighed the concerns initially identified by A&E staff. The fact that a significant injury could be the first indicator of further abuse was not fully explored.
- In agencies' involvement with both child A and child B there was an over reliance on what was said by Ms J. This danger has been highlighted in the Ofsted '*Learning Lessons Report*' 2008. This resulted in the child not being at the centre of all assessments and interventions.

#### 4.1.3 **Consideration of a child as part of a wider family system and the need to involve *all* relevant family members and partner agencies in interventions**

- The agencies who had contact with child A obtained limited information about the family structure. Child A's father (Mr E) has stated that he did attend appointments for child A's faltering growth but that Ms J excluded him from child B's appointments with the child and adolescent mental health clinic despite being an actively involved step father.
- The fact that this was a newly constituted family unit was missed at child A's hospital admission in early December 2008. Consequently there was no holistic assessment of the family unit at that time.

#### 4.1.4 **Compliance with guidance and procedures in respect of referral of a child under 3 years with a serious injury to Children's Social Care and Police**

- The concerns identified at the time of child A's presentation at hospital 1 in early December 2008 were potential indications of abuse and a referral should have been made to Children's Social Care prior to his discharge, in line with the hospital's written child protection procedures.
- Kent & Medway Safeguarding Children Procedures and the Royal College of Paediatrics and Child Health guidance give clear direction that, if abuse is *suspected, alleged or confirmed* during a presentation at a hospital, the child should not be discharged until a referral has been made and a strategy discussion or pre-discharge meeting has been held. This did not happen in this case as it was concluded the injuries were accidental.

## 5 RECOMMENDATIONS

### RECOMMENDATIONS MADE AT THE TIME OF THE SSERIOUS CASE REVIEW IN JULY 2009 AND SUBSEQUENTLY ACTED UPON

#### 5.1 INTRODUCTION

5.1.1 Recommendations have been accepted and have been acted upon by the appropriate safeguarding board or individual agency.

- An interagency Action Plan was produced and all actions have now been completed. The completed Action Plan will continue to be monitored by Bexley LSCB.

#### SAFEGUARDING BOARDS

##### BEXLEY LSCB

5.1.2 Bexley LSCB should:

- Check that the required actions specified below for Bexley-based agencies are completed effectively in accordance with the timeframe described for each one [by 30.09.09 and thereafter within routine audits]
- Organise multi agency briefing session/s where results of this (and other SCRs) can be shared and discussed with professionals [by 31.01.10]

##### KENT LSCB

5.1.3 Kent's LSCB should:

- Initiate monitoring of compliance with the recommendations that are of *particular* relevance to the Kent-based hospital 1 [by 31.07.09]
- Also consider the implications of its school IMR that implies a wider need to review and improve formulation / detail and retention of records in primary schools [by 31.10.09]

##### DARTFORD & GRAVESHAM NHS TRUST (HOSPITAL 1 IN KENT)

5.1.4 Hospital 1 should ensure that:

- An interagency Action Plan was produced and all actions have now been completed. The completed Action Plan will continue to be monitored by Bexley LSCB

- Wording on the internal assessment document for suspicious injuries is changed from a 'check' to 'refer' (the changes and accompanying advice should be disseminated to all relevant staff) if such wording exists in any documentation [by 31.07.09]
- A consultant paediatrician reviews the documentation of all children about whom there are safeguarding concerns prior to discharge, to ensure that completion of a comprehensive assessment, and that all investigations and concerns have been documented, followed through and accounted for [by 31.07.09]
- If information is sought about whether a child is 'known' to Children's Social Care', it is done via a 'consultation' and staff ask to speak to the duty social worker in order to share and obtain information [by 31.07.09]
- Any child admitted with an unexplained fracture should be reviewed by the consultant orthopaedic surgeon in charge of her/his care [by 31.07.09]
- Orthopaedic teams document the outcome of discussions of the X-rays of paediatric patients at daily trauma / X-ray meetings, in the child's medical notes [by 31.07.09]
- Any child who attends A&E with an unexplained injury, should be routinely referred to Children's Social Care [by 31.07.09]
- Medical discharge summaries for children about whom there have been safeguarding concerns, when leaving the inpatient paediatric ward, must be comprehensive, detailing the safeguarding concerns during the child's admission, and outlining all actions taken and conclusions reached [by 31.07.09]
- All relevant staff are reminded at briefing sessions and in writing of the guidance set down in the Kent / Medway procedures and the RCPCH Companion about the discharge from hospital arrangements who have suffered fractures
- All relevant staff are reminded of the need to establish and record parental / legal status of adults accompanying or visiting child patients [by 31.12.09]
- The safeguarding team record all A&E attendances phoned to health visitors / school nurses as a result of safeguarding issues [by 31.07.09]

## **SOUTH LONDON HEALTHCARE TRUST (HOSPITAL 2 IN BEXLEY)**

### 5.1.5 Hospital 2 should:

- Amend the wording on the internal assessment document for suspicious injuries from a 'check' to 'refer' [by 31.07.09]
- Initiate an internal review on how to improve the documentation process in A&E and information sharing with the health visiting service about children who fail to attend hospital appointments [by 31.10.09]
- In dedicated briefing sessions and associated written material for all relevant staff disseminate the results of this SCR; especially the links with fractures / abuse in young children; importance of information sharing with agencies before discharging a child in whom abuse has been suspected and requirements of the London Child Protection procedures and the RCPCH child protection [by 31.12.09]

## **BEXLEY CARE TRUST**

### 5.1.6 Bexley Care Trust should:

- Initiate reviews about: - existing information sharing systems between general practice and health visiting; existing guidelines on 'follow-up' for mothers identified as being, or at risk of being significantly post-natally depressed and its standard on monitoring growth to ensure children identified with faltering growth are observed feeding and assessed in the home; about the liaison arrangements between hospital 1 and Bexley health visiting teams about children presenting with safeguarding concerns, particularly injuries to young children [by 31.12.09]
- Ensure that training for GPs includes particular reference to prioritising injuries to young children [by 31.10.09]
- Ensure that induction provided to all locum GPs includes appropriate child protection guidance [by 31.10.09]
- Initiate a time limited discussion with GP surgeries to trigger development of procedures to ensure that safeguarding issues about children and families who do not attend appointments to specialist services are followed up appropriately [by 31.10.09]

## **BEXLEY CHILDREN'S SOCIAL CARE**

### 5.1.7 Bexley Social Care should:

- Notify all relevant agencies that pro tem, any other agency wishing to check if a child is 'known' will be connected to a qualified safeguarding social worker whilst a tighter auditable system is developed [by 30.06.09].
- Develop a facility on its Integrated Children's System (ICS) to record agency enquiries made about children subject to child protection plans and develop a procedure to ensure such enquiries are recorded and passed on to the duty social worker [by 31.10.09]
- Review the process for closing off cases which involve families / parents who do not complete the work at the family centre or who disengage from services offered as a result of initial assessments [31.12.09]
- Issue a written reminder from the head of service to all social work staff of the requirement that children are seen as part of the assessment process (or a record and explanation offered if this does not happen) [by 31.07.09 and subsequent compliance audits]

## **OXLEAS NHS FOUNDATION TRUST**

### 5.1.8 Oxleas Trust should:

- Remind all professionals in writing that assessments should incorporate all aspects of the child's presentation and history including; gathering information from other relevant agencies so that any safeguarding concerns may be recognised [31.07.09]
- Develop a 'review / risk assessment process' for cases when a child / family disengage with CAMHS following initial attendance [by 31.12.09]
- The CAMHS clinic should consider and offer proposal for practical response to be made when families are not engaging well, or there is a pattern of non engagement, so that the focus remains on the child, and that opportunities to see her/him are maximised [31.01.10]

## 6 TERMS OF REFERENCE

Bexley LSCB has a standing Serious Case Review (SCR) Panel with senior membership from the LSCB Partner Agencies. It has its own Terms of Reference. This Panel is independently chaired and for the purposes of this SCR, Kevin Harrington (Kevin Harrington Associates Ltd), who has extensive experience of all aspects of SCR processes, has been appointed as the Chairman. He is entirely independent of any Bexley agency.

The decision to convene a serious case review was made by the Chairman of Bexley LSCB, Dr Deborah Absalom.

The agencies making up the standing membership of the Serious Case Review Panel are:

- Deputy Director (Social Care & SEN), LB Bexley Children & Young People's Services
- Designated Doctor, Bexley Care Trust
- Designated Nurse, Bexley Care Trust
- Deputy Chief Executive, Queen Mary's Sidcup NHS Trust (now South London Healthcare NHS Trust)
- Director of Nursing & Governance, Oxleas Foundation NHS Trust
- Partnership Officer, Bexley Voluntary Service Council
- Head Teacher, Bexley Schools
- Police Superintendent Operations, Metropolitan Police Service (Borough Police)
- LSCB Manager, Bexley LSCB

For the purposes of this SCR the following have been invited to join the Panel:

- SCB Manager, Kent SCB
- Director of Nursing, Dartford & Gravesham NHS Trust

The Panel is deemed to be quorate if the Chairman and at least 4 agencies are represented, including health and social care services.

The Panel will provide independence and challenge. It will recommend the Overview Report to the LSCB for sign off.

The Panel will be responsible for updating OFSTED / GOL as necessary in respect of any issues arising from this SCR.

### 2. Background Information

This SCR involves child A who died in late December 2008. Child A lived with his mother and older sibling, His mother had a new partner of 3 months standing. Child A was in regular contact with his father and had spent Christmas in his care.

Child A was taken by ambulance to hospital 2 on the day of his death at 09.40 and pronounced dead 10 minutes later. It was noted that 'rigor mortis' was present on arrival. The preliminary post mortem indicates that he had sustained 2 types of

injury, both of which were life threatening but possibly aged differently. His injuries were extensive. Mother and her partner were arrested and bailed.

Child A was not known to Children's Social Care but had accessed services through universal agencies. On 8/9 December 2008 he had been treated at hospital 1 for a fracture to his leg.

### **3. Key Issues**

In addition to the standard SCR terms of reference for management reviews and the Overview Report (as set out in Working Together paragraph 8.12 and pages 174 to 177 incl.) all of which are to be applied, the SCR Panel has considered the information currently available in agreeing the Terms of Reference. Issues identified at this stage from which lessons may be learned include the response by universal services to any indicators of concern for child A and / or child B, and the management of child A's presentation at hospital in early December 2008.

Therefore the specific additional terms of reference for this particular case are as follows

- The nature of information sharing and joint agency analysis and planning at all stages of the case in the time period under review
- The decisions made in respect of the health care needs of child A following his presentation at hospital in early December, what further enquiries in respect of safeguarding child A were made and the adequacy overall of the safeguarding response to that presentation
- Whether there were indications of safeguarding issues arising from any other assessments of child A's health and development
- Whether there are any concerns from the historical contact with child A's mother and his sibling, child B, including in particular the approach to parenting of the mother, Ms J, that would indicate the need for a safeguarding response
- Whether any causes for concern might have been identified by any agency in relation to changes in the family's circumstances in recent months
- The existence and availability of procedures and good practice guidance for use by individual practitioners and managers; how fit for purpose such procedures or guidance are and the reasons why individual practitioners or managers may not have complied with any procedures or good practice guidelines

### **4. Independent Author**

An Independent Social Work Consultant with over 20 years experience in Local Authority Children's Services was initially appointed to draft an overview report. As well as being an experienced manager in safeguarding services she has experience of conducting Serious Case Reviews and writing Individual

Management Reviews as well as participating in Complex & Organised Abuse Investigations. She will also be able to draw on supervision through her Agency from an experienced Overview Writer.

The Overview Writer will produce the integrated chronology, integrated action plan, Overview Report & Executive Summary, and present these to the SCR Panel and the LSCB [in the event Fergus Smith, CAE Ltd [www.caeuk.org](http://www.caeuk.org) was asked to re-analyse all material collated and present an overview report to the SCR panel in July 2009]

## **5. Requirement for Independent / Expert Advice**

There is no indication that expert advice is required. This will be kept under review by the SCR Panel and commissioned by individual agencies, or by the Panel as required.

## **6. Time Period to be covered**

The time period of the review will focus on the period from the confirmation of the mother's pregnancy with child A, approximately July 2006. The review will also consider any relevant information to provide background and context relating to child A's sibling, child B (aged 9yrs) however historical. Any agency involved with the parents and mother's current partner should provide chronologies of their involvement/contact with the adults relevant to this review, however historical.

## **7. Organisations participating in the Review**

The following organisations have been identified

- Bexley Care Trust
- Dartford & Gravesham NHS Trust
- LB Bexley Children's Social Care
- Child B's Primary School
- Oxleas Foundation NHS Trust
- Queen Mary's Sidcup NHS Trust
- Metropolitan Police Service
- London Ambulance Service
- Kent SCB

Each participating organisation will submit a chronology, in a consistent format, of their involvement with child A, child B, child A's Mother, Ms J, her partner, Mr D, and child A's father, Mr E.

The SCR Panel will determine which organisations are required to submit an IMR, and which organisations will be requested to provide background and contextual information. LB Bexley Housing Options Team and Lewisham SCB will be asked to provide background and contextual information to the Panel, in the first instance.

IMRs should be written in line with the guidance in Working Together Chapter 8 (8.27) and the provided framework. The chronologies will be completed using the provided template.

## **8. Involvement of family members**

Child A's parents will be formally notified by the LSCB of the decision to conduct a Serious Case Review. Subject to liaison with agencies involved in any criminal investigation, child A's parents will be invited to meet with the Overview Writer and a Panel member to ensure that their perspective is fully explored and their views are reflected in the final report. The parents will also be invited to suggest any other members of the extended family who may be able to contribute to the Review.

## **9. Parallel Investigations**

Criminal and coronial investigations are underway. Serious Untoward Incident investigations will be undertaken by the relevant hospitals. The links between these processes will be co-ordinated through the SCR Panel.

## **10. Involvement of other localities.**

There are implications arising from this SCR for Kent SCB. Kent SCB and Dartford & Gravesham NHS Trust will be represented on the SCR Panel and the Kent Primary School has been identified as participating agencies. Lewisham SCB will be asked to contribute any relevant background information.

## **11. Liaison with Coroner / Police / CPS**

Continuing liaison will be necessary and will be co-ordinated by the SCR Panel.

## **12. Parallel Reviews**

There is no indication that any parallel Reviews are necessary.

## **13. Involvement of any non-statutory organisations**

Any such involvement will be co-ordinated by the SCR Panel.

## **14. Start and Completion Dates**

The SCR was initiated on 5<sup>th</sup> January 2009 and will be completed by 5<sup>th</sup> May 2009

## **15. Media Management**

The SCR Panel will co-ordinate media management, establishing a sub-group if necessary.

## **16. Independent Legal Advice**

There is no indication that this is indicated but this will be kept under review by the SCR Panel.

## **17. Confidentiality**

The SCR will be conducted in a confidential manner. The IMRs and any other reports produced for the SCR must not be shared. The Overview Report remains a confidential report for the LSCB. The Executive Summary will be published in line with guidance.