CHILD PROTECTION INQUIRY

into the circumstances surrounding the death of

Kennedy McFarlane, d.o.b. 17 April 1997

commissioned by Dumfries & Galloway Child Protection Committee

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EXECUTIVE SUMMARY

Following the tragic death of three year old Kennedy McFarlane on the 17th of May 2000, Dumfries and Galloway Child Protection Committee(CPC) commissioned an immediate inquiry into the circumstances which led up to her fatal injury. The object of this inquiry is not to apportion blame but to learn lessons which will help to protect children from abuse and neglect in the future.

This inquiry has been multi-part, commencing with a detailed internal examination of records made and processes followed, and followed by an external review led by myself supported by a reference group drawn mainly from members of the CPC. The inquiry has followed closely the format laid down in the document 'Working together to Safeguard Children' in England and Wales (1), widely known as part 8 reviews, to be instituted where a child dies in circumstances where abuse or neglect are known or suspected to be a factor. Although this process is not currently a statutory requirement in Scotland it was felt Kennedy's death raised many of the questions the format aims to address, and therefore would be appropriate. The process has included perusal of all records, and procedures, and interview of all the key staff involved in her care or in the relevant local interagency services.

The review and compilation of the report was required within a very tight time frame with the murder trial originally scheduled for September. This has precluded any detailed inquiry into wider issues which have emerged from the examination of this case. Some discrepancies have arisen in terms of dates and sequence of events in the detailed accounts of professional involvement. These do not in my view detract from the main issues and conclusions which emerge.

My inquiry has confirmed that Dumfries and Galloway have in place Child Protection practice and procedures in keeping with current guidance which, fully invoked in Kennedy's case, would, in my view, have led to her protection. It is also clear that there are staff at all levels in the organisations with training, experience and commitment to working with children and families in vulnerable situations. In this case however these procedures, which should have led to full multi-agency investigation, risk assessment, and a child protection care plan, were never fully instituted ..

It is clear from this inquiry that, as in previous tragedies of this nature, no single person or agency was to blame for Kennedy's death. I am in no doubt that all the staff involved did their best in difficult circumstances. I do not believe that anyone could have predicted the sudden and violent death which occurred on 17th May. However a number of opportunities to identify the extent of the risks to Kennedy and for effective intervention had arisen as the case unfolded and these are detailed within the report. In response to many of these, particularly the serious eye injuries and the drug ingestion, I would have expected experienced professionals in both health and social services to have acted differently.

It is still not entirely clear why this did not happen and it is likely that many factors were involved, and the following were recurring issues throughout the inquiry:

- Lack of effective communication and joint decision making.
- Lack of effective documentation and presentation of the medical evidence and thus a failure to give an explicit account of the inherent risks to Kennedy's safety.
- Inappropriate reliance on the opinions and advice of others.
- Over-confidence in decision taking by/of team managers and a failure to recognise the need to introduce checks and balances by testing out theories and plans with experienced colleagues.
- Unchecked assumptions about the involvement and views of others.
- Heavy workloads and problems with the availability of professional/specialist support.

Some at least of these issues had already been brought to the attention of the relevant agencies in relation to other cases.

As a result, by the time of her discharge on 5th May 2000, despite the repeated concerns, referrals and admissions, a formal child protection investigation had not been triggered and no-one had put all the pieces of the puzzle together creating a total picture of escalating harm within the context of a family in need. I have no doubt that if a joint investigation into all the circumstances around this little girl from the end of 1999 to early May had been instituted there would have been enough evidence already available to satisfy a Sheriff of the need to protect her in a place of safety whilst a risk assessment was completed.

It is my opinion that once the full information was collated, including particularly information now available from the natural father' s family and in relation to mother's own difficulties, that there would have been enough evidence of continuing risk of significant harm, to prevent her return to the maternal home. It is therefore my conclusion that although on 5th May her violent death could not have been accurately predicted it could have been prevented.

I have made a number of recommendations, some of which have already been responded to by the agencies concerned singly or jointly. Some will be more difficult to address arising from interpersonal and geographical constraints. It has been my experience throughout that Dumfries and Galloway staff are committed to taking the necessary steps to address the problems which have arisen in this and other child protection cases. Some of my conclusions and recommendations will be equally applicable to other areas of Scotland, particularly those remote from specialist centres, and will be raised with the Scottish Executive.

In my commentary I have set this inquiry in the context of previous inquiries into child abuse tragedies recognising the similarities and therefore the potential prompts to identifying the risk of fatal outcome in Kennedy's case. This highlights the need to learn the lessons from research and inquiries and not to simply apportion blame to a few individuals. It also acts as a reminder that, however good our systems we will never be able to predict or prevent all child deaths at the hands of their carers just as we cannot prevent all child deaths from accident or illness.

CHILD PROTECTION INQUIRY: DUMFRIES AND GALLOWAY

1. INTRODUCTION

Background to inquiry

Following the tragic death of three year old Kennedy McFarlane d.o.b.17.04.97 on the 17th of May 2000, Dumfries and Galloway Child Protection Committee (CPC) commissioned an immediate inquiry into the circumstances which led up to her fatal injury. The object of this inquiry is not to apportion blame but to learn lessons which will help to protect children from abuse and neglect in the future. This inquiry has been multi-part with a detailed internal examination of all the records made of professional contacts with Kennedy and her family, and an external review led by myself, as a Consultant Paediatrician with considerable experience of specialist medical and interagency working in child protection in Lothian. I have been supported by a reference group of senior professionals and managers in Dumfries and Galloway led by the chair of the CPC.

The inquiry has followed the format laid down within the document 'Working Together to Safeguard Children' from the Department of Health, Home Office and the Department for Education and Employment, London, 1999 known widely as Part 8 reviews (1). This process of review has been introduced in England and Wales to be invoked when a child dies in circumstances where abuse or neglect are known or suspected to be a factor. Although this procedure is not a statutory requirement in Scotland, and Kennedy was not on the Child Protection Register or a 'looked after' child at the time of her death, her death raises many of the questions the process aims to address, and therefore this format was seen to be the most appropriate. The purpose of case reviews carried out under this guidance is to:

- Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard 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;
- To improve interagency working and better safeguard children.

Scope and Timing

Dumfries and Galloway Child Protection Committee (CPC), under the chairmanship of the Head of Operations, Social Services Department, set up a reference group to oversee the process and rapidly set in motion the individual agency audits from Health, under the leadership of a Consultant Paediatrician from a neighbouring health board, and Social Services, collated by the Children's Services Manager. Dr. Hammond then met with the reference group to plan the gathering of further information including an opportunity for Dr. Hammond to interview identified 'key players'. The planned time frame was very tight due to the imminent criminal court procedures due to commence on 11.09.00. Difficulties were inevitable due to the inquiry falling at the main summer leave period.

The Reference Group

The members of the reference group drawn together by the Child Protection Committee are detailed in Appendix (1).

In undertaking this inquiry I had access to all involved personnel the Health and Social work audits and supporting documents/correspondence. In addition I was provided with the current interagency and individual agency child protection guidelines, standard documentation and training programmes and documents. I was ably supported by senior personnel in social work and health and by administrative from Grierson House particularly from an experienced minute taker who took minutes of almost all the interviews with staff.

My background

Dr Helen Hammond graduated from Oxford University in 1973 and is a Fellow of the Royal College of Physicians in Edinburgh and of the Royal College of Paediatrics and Child Health.

Dr Hammond is a Consultant Paediatrician, responsible for the Community Child Health Services in West Lothian Healthcare Trust and taking a full part in the acute Paediatric rota for the Children's Ward at St John's Hospital. She has a special interest in Child Protection, Adoption & Fostering and Child Development, particularly of very young children. She spends just over 50% of her working week in relation to child protection cases including case-work, organisational and training responsibilities. She has led the development of Specialist Paediatric and joint Paediatric/Forensic Clinical Services across Lothian and taken an active role in the development of peer review in Scotland.

She is the Vice Chair of the Lothian Child Protection Committee and the Chair of the Health Sub-Group of that Committee and has been actively involved in the development of the Lothian Child Protection Interagency and Health Guidelines. More recently she was the Paediatric Representative in the Scottish Executive Working Party developing health guidance for Health Trusts and Boards across Scotland.

She is a member of the Council and Academic Board of the Royal College of Paediatrics and Child Health and recently became a member of the Standing Committee for Child Abuse and Neglect for the Royal College. In 1998 she completed an MSc in Forensic Medicine and acts increasingly as an Expert Witness in child abuse cases led both by the Prosecution and Defence Teams.

2. THE FACTS

2.1 The setting: Dumfries and Galloway

Dumfries and Galloway (D&G) covers a geographical area of 2,500 square miles, and with a population of 148,000 is one of the lowest populated regions on mainland Scotland. In 1996 there was a total of 34,020 children in D&G, with 8,650 under fives. Household

incomes are significantly below the Scottish average and rising male unemployment is a feature. Local Authority and Health professionals work closely together both in terms of field-work and management and planning of services. Health and Social service offices are housed together in Grierson House in Dumfries. Despite the reorganisation into and acute and primary care Trusts a combined Child Health service aiming to deliver seamless care between general practice, community based services and hospital has been set up over recent years and is strongly supported by practitioners and managers. In relation to child protection services, child protection officers for health (a nurse) and social work services are in post and indeed share the same office.

In March 2000 there were 55 children in 32 families on the child protection register in D&G. This represented a 34% drop in registrations over the previous 3 month period. Fig (1) shows the breakdown in terms of type of abuse and it is particularly interesting to note the high proportion of cases registered under the category of neglect.

Figure 1

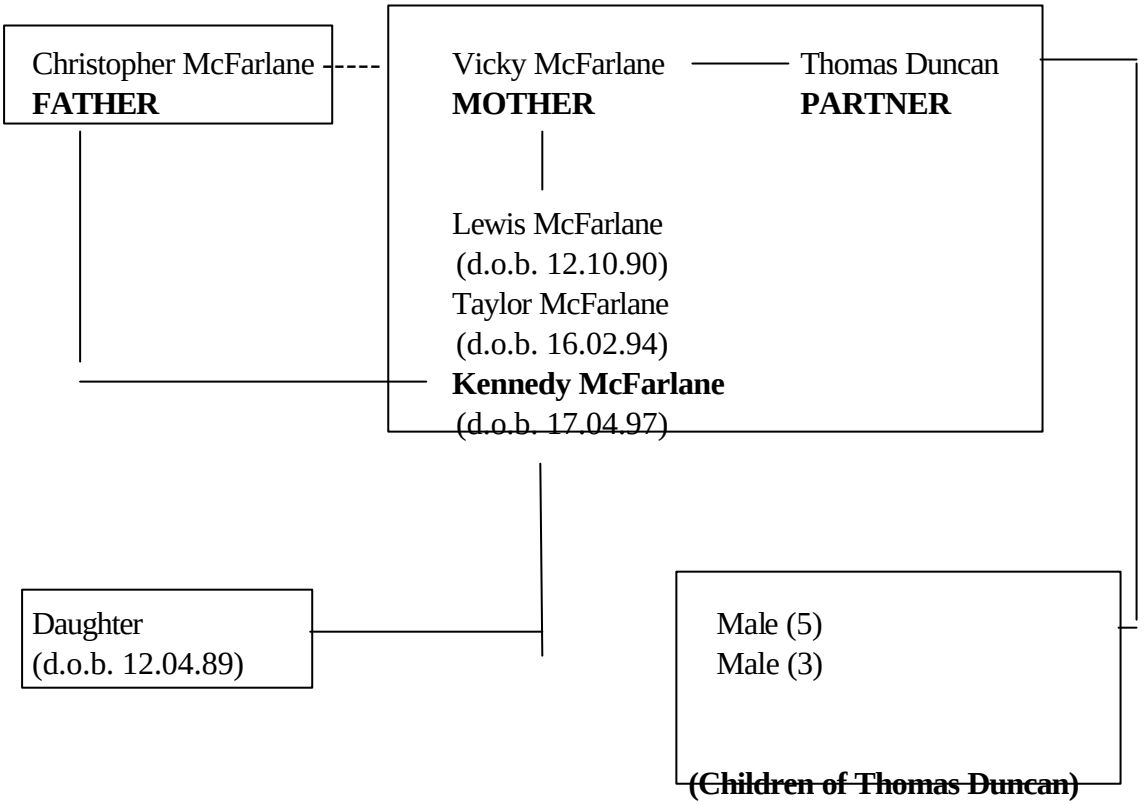
Category		**A/Eskdale**	**Nithsdale**	**Wigtown**	**Totals**	**%of total**
for	Physical	12	6	6	24	44%
Registration	Emotional	0	4	3	7	13%
	Sexual	0	3	3	6	11%
	Neglect	1	11	6	18	33%
	FTT	0	0	0	0	0%

59 children were on supervision orders under the Children's hearing system residing at home, 114 were accommodated in foster placements and 31 were in residential care. It is of note that Dumfries and Galloway have a relatively low number of children on the Child protection register per head of child population - 1.6 per 1,000, a fact which seems particularly surprising given the social profile of the area it serves. West Lothian, with a similar child population (38,000 under 16 years, including 10,000 pre-school)) has 90 children on the register following 234 referrals for child protection concerns during the 12 months of 1999. This gives a rate of 2.4 per 1,000 well below the figure for the city of Edinburgh at 4.4 per 1,000 and in keeping with the Scottish figures for 1998-1999 which were 2,373 children on the register, representing 2.3 per 1000 population under 16 years.

2.2 The Key Players:

The family

Kennedy lived with her mother Vicky McFarlane her mother's partner Thomas Duncan and her half siblings Lewis and Taylor. She went for regular access visits to her father Chris McFarlane and his grandparents.



The professionals

Health staff

Family health visitor (HV)

Family general practitioner (GP)
Consultant Paediatrician for Kennedy and the lead paediatrician for Child Protection for Dumfries and Galloway (Con.Paed 1.)
Consultant Paediatrician (Con. Paed 2)
Consultant Paediatrician (Con.Paed 3)

Child Protection Advisor-Health (CPA-health)

Ward Sisters: (WS1) (senior) and (WS2)

Social Work staff.

Paediatric social worker (PSW) Hospital based
Family social worker (FSW) geographically based
Team manager (TM)- short term assessment team
Child Protection Officer-Social services (CPO-SW)
Operational manager-Children and Families(OM)

Police

Detective inspector- Family Protection unit (DI-FPU)

These members of staff have all been interviewed in the course of the inquiry. Appendices 3 and 4 detail all the professionals for health and social services involved in Child Protection Services in Dumfries and Galloway and the management structures they work within.

Detailed factual information for the inquiry has also been gathered prior to my involvement by an internal audit of health and social services input gathered by a senior consultant in general paediatrics from a neighbouring health board and a senior member of the Social Services department in Dumfries and Galloway, with extensive child care experience,

2.3 The diary of main events

DIARY OF MAIN EVENTS

Between Kennedy's first referral on 28.01.00 and her death on 17.05.00

28.01.00 referral from playgroup re marked decline in Kennedy's well being (received by Social work)

02.03.00 admission with serious eye injuries-bilateral corneal abrasions (received by Health)

23.03.00 referral from playgroup re bruising to face , back pain and reiterating ongoing concerns re general well being, relationship with cohabitee etc. (received by social work)

20.04.00 and 24.04.00 admissions with bruising, ataxia, drug ingestion, (received by health passed to social work by phone and letter)

28.04.00 Planning meeting (Health and Social work)

05.05.00 Discharged from ward (health) (social work arranging case conference)

NO FURTHER HEALTH or SOCIAL WORK CONTACT

16.05.00 admitted to intensive care

17.05.00 **DIED**

2.4 The interview process

Following my initial perusal of the records and the information gathered in the internal health and social work audit, further questions were identified in discussion with the reference group. Many of these could be answered by senior management colleagues having further discussions with the professionals concerned which was undertaken speedily for me. However it was my view that a full inquiry into the circumstances which led to Kennedy's death could only be completed if I had an opportunity to interview key professionals. This would allow me not only to gather any missing factual information and to clarify any apparent or real inconsistencies in those facts but also to gain insight into the working relationships both within and between agencies and the way in which these may have influenced events. We therefore identified key professionals in health and social work and arranged for them to be invited to attend and to bring a support person with them if they so desired. The interviews were all minuted by an experienced clerical officer. Interviewees have had a subsequent opportunity to check these minutes and to add to the information if they so wished.

In each interview I followed an agreed format of stem questions which were adapted to suit the role of each individual, these started by exploring the interviewees experience and training, their job description and their role in child protection. I went on to consider their access to support and ongoing training and working relationships within their teams. I then turned to a consideration of their involvement in the case focussing on what we had identified as the five crucial times as outlined on the diary of events Appendix A, starting with a referral from playgroup, moving on to the eye injuries, then the admission with ataxia and bruising, the planning meeting and the final discharge from the ward on 5 May 2000. Discussion about the additional referral from playgroup on 23 March 2000 in relation to bruising and back pain did not involve the hospital staff but was discussed with the community and social work professionals. At each of these stages the professionals were encouraged to consider their own role and perceptions at the time, their recollection of the reported advice they received from professionals in other agencies and invited to comment with hindsight on whether or not they might have acted differently. All the interviewees were asked about what support and counselling they had received following Kennedy's death and invited to make any other contribution which they felt was relevant.

All the professional staff interviewed were co-operative and forthcoming. Some were extremely upset and with clear feelings of guilt about their failure to protect Kennedy but others still feeling that they did what they could and that there were no legal grounds to protect her. All have identified some procedural difficulties and agree that systems and communications can be improved. Some are clearly in need of professional help in coming to terms with what has happened.

An undertaking was given to the staff that the contents of their interviews would only be shared with the Reference group and their individual line managers and are therefore not included within this section of the final report. **The information and views gathered has been vital to understanding how events evolved and how to move forward.**

2.5 Health Involvement

Summary of main events

Kennedy was born on 17.04 97 at Cresswell Maternity Hospital, Dumfries. No specific concerns are noted in the records either relating to her birth or neonatal progress or to her early infancy. Although she was quite a frequent user of GP services in the first year of life the reasons cited are unremarkable. Although her mother failed to bring her for her MMR immunisation in January 2000, this in itself was unremarkable. However, February 2000 sees the beginning of a series of GP attendance's which do start to raise significant concerns and it appears from the health audit and a noted telephone discussion with the GP that he was becoming increasingly concerned.

The description of **hair falling out and soiling on 17th and 22nd February** is particularly worrying and led to the GP asking the health visitor to become involved. The HV had not informed the GP about the concerns about Kennedy's physical presentation which had been recently raised by the playgroup so that this would not have influenced their evaluation. Nor is it clear whether they took into consideration the concerns about mother's own health and use of medication (possibly including illegal drugs) in thinking about Kennedy's care at this stage or subsequently. There are no records of Kennedy's growth over this period.

On **27th February Kennedy is seen for the first time with her eye injury**. The eye is swollen and Kennedy is unable to open it. The GP, a different doctor on this occasion, diagnoses conjunctivitis and corneal abrasion and prescribes antibiotics. She asks to see Kennedy for review in 3 days if she is no better. She appears to have accepted the mother's explanation that Kennedy's brother caused the injury by hitting her in the eye 3 days earlier. Two days later she is no better and further review is planned for 2 days. The following day **02.03.00 she is seen by (GP) with a persisting sore eye? orbital cellulitis and now generally unwell and referred for admission** to the children's ward and for urgent ophthalmological opinion.

In between these contacts Kennedy was seen by the HV who visited on 29.02.00 in response to the GP's referral about the soiling. She noted that Kennedy had bloodshot eyes but appears to have accepted both the mother's explanation of the video incident and that the child was receiving appropriate care from the GP. She also notes that K does not interact with the new cohabitee Thomas Duncan. There is no comment in her notes about her thoughts about all these circumstances particularly in the light of the playgroup's concerns.

On 03.03.00 the hospital team, Con. Paed 1, the eye consultant, and the PSW, seem to have clearly identified concerns about the possibility of NAI in relation to the eye injuries. **Examination under anaesthetic confirmed bilateral corneal abrasions not compatible with mother's history.** The Ophthalmologist (Eye Consultant) discusses this with the on call consultant paediatrician after theatre and she recommends he speaks to Con Paed 1 as the lead clinician child protection. Con. Paed 1 and PSW interview the mother

that afternoon and she repeats her story of the brother hitting Kennedy with a video while sleep walking. Unfortunately by the time Con Paed 1 speaks to the Eye Consultant after this interview he recalls a further explanation given by the natural father that Kennedy ran through bushes at Charlie Chalks on the Sunday and he accepts this as a possible explanation. (It was subsequently clarified that the possibility that these injuries was caused was running though bushes was first put to the father by the eye consultant)

No-one seems to question how the child could have sustained these severe injuries without it being immediately obvious to the caring adult, or made any attempt to check the scene to see if it was feasible, surely a job for the police. The significance of the changing stories was also missed particularly again in the context of what was already known to the agencies. The decision is taken by social work not to involve the police but to hold a planning meeting. It is not clear from the medical notes why this did not take place before discharge or what the professionals' expectations or understanding of the role of a planning meeting was and what it could achieve.

Despite Con Paed 1's initial concerns she discharged Kennedy on 05.03.00 after her further discussions with the Eye Consultant.

06.03.00 Record of telephone discussion between CPA-health and PSW expressing ongoing concern re origin of eye injury. Still focussing on the original story of the video. CPA-health advises PSW to seek opinion from a clinical psychologist on the likelihood of the sleepwalking story being possible. There is also a note here that social work were having difficulty getting a coherent history from the general practitioners. The GP notes record the Social work contact for information and the changing history as recorded in the discharge letter.

07.03.00 Home visit by health visitor re soiling. Mother reporting some progress. No mention is recorded of the recent admission or the concerns about the possibility of non-accidental injury as the explanation for the eye injuries.

07.03.00 The health audit records contact from playgroup re sore back and bruised left cheek. However this information did not reach the GP notes until after the planning meeting. This is the first mention of Kennedy complaining of a sore back, which is, as Con Paed A notes, an unusual complaint for a three-year-old.

09.03.00 Eye appointment for review 16th March-attended.

?10.03.00 CPA-health 'in passing' to PSW shared the information that the story of the eye injury now changed to the bushes at Charlie Chalks. CPA-health indicates that she did not think there were bushes at Charlie chalks.

22.03.00 Kennedy is taken to the GP with a history of a sore back for a few days and reduced appetite. GP wonders if this might be a urinary tract infection but Kennedy has no other suggestive signs o symptoms of this. She is prescribed antibiotics.

5.3.0 The HV is informed by a duty social worker that there has been an anonymous allegation re a back injury to Kennedy within the last week and another bruise to her cheek. Social work are to visit. It is not clear whether the HV shared this with others in particular the GP who might have reconsidered his diagnosis. Social work records indicate that the HV reassured them that her only ongoing input was in relation soiling and she was not expressing serious concerns. This seems surprising given the information available to her at this stage.

28.03.00 Home visit by the HV discusses soiling and brother's sleepwalking. No mention about the back pain, eyes or bruising.

13.04.00 Eye clinic review. Corneal abrasions now well healed.

20.04.00 Seen by the GP with further episode of back pain. Kennedy is refusing to walk. She has bruises to her right temple and cheek. Thought to have fallen off a swing the previous day. **GP refers her for admission and mentions the previous concerns re possible non-accidental injury of the eyes in his letter as well as concerns about the origin of these bruises.**

20.04.00 Admitted to the children's ward by the on call consultant paediatrician. Found to have bruising to her back forehead and cheek and to be unsteady on her feet. It is of note that her mother had been admitted the previous evening with a fit. This paediatrician orders investigations but another consultant on the ward round the following day 21.04.00 appears to accept mother's explanation supported he feels by her photograph of the swing and discharges her despite his colleagues concerns, the unexplained unsteadiness on admission and the abnormal liver function tests.

21.04.00 (Good Friday) At 21.30 biochemistry report comes through showing that K has carbamezepine metabolites in her urine. The consultant on call is informed and asks for Kennedy to be invited for repeat liver function tests a week later. Kennedy's Mother is phoned to tell her about this finding.

24.04.00 (Easter Monday) Mother returns to the ward without an appointment to speak to Con Paed 1 expressing her concerns about Kennedy's well-being since March. She had found her the previous evening with 2 carbamazepine tablets in her mouth and gave a bizarre story about the possibility that Kennedy had taken a number of tablets hidden them and was taking them regularly herself. Con. Paed 1 did not believe this story but was very concerned and suggested readmission to which mother readily agreed.

On admission on 24.04.00. Kennedy was not ataxic but had the bruising as previously described. Con. Paed 1 was very concerned and made a referral to social work for multi-agency investigation by writing a 'to whom it may concern letter and informing the CP officer health.

25.04.00 HV receives information re earlier discharge and speaks by phone to PSW. HV visits the house. No reply – Kennedy back in ward. Mother phones HV later to tell of admission.

26.04.00 The health audit states: Con Paed 1 phones the CPA seeking advice. The .toxicology shows carbamezepine in urine, bruise on face. The CPA advises urgent referral to SW seeking investigation and Child Protection Case Conference ("CPCC"), would recommend that Kennedy should not be discharged until SW investigation.

28.04.00 **Planning meeting see SW audit and minutes. Minutes state "agreed Kennedy to go home once medically fit for discharge. HV will continue to support the family**". Con. Paed 1 is clear that she did not agree to this decision and the minutes are inaccurate**.** The health visitor states that she did not undertake to monitor Kennedy on a regular basis but to continue with her own role which would include three year check and further visits to advise re toilet training and other health/development issues**. The minutes of this meeting were not circulated prior to Kennedy's death**.

05.05.00 **K discharged.** The health staff all appear to have been unhappy with the decision to discharge before the investigation was complete and a conference convened but did not clearly challenge the decision. **Nursing records note 'no legal grounds to keep her'. No clear medical follow up plan recorded apart from two week review on the ward and attendance at the eye clinic. Con Paed 1 made aware that there was now agreement from TM to call a case conference but no date had been agreed. No direct contact made with health visitor to alert her to discharge.**

08.05.00 HV receives discharge slip and speaks to CPA-health who advises HV not to visit for a couple of days because of tensions. HV never sees Kennedy again. CPA chance encounter with SW cannot remember what was said.

10.05.00 Invitation to CPCC on 25.05.00 received by health professionals.

11.05.00 CPA establishes that it is unlikely that Con Paed 1 will be able to attend CPCC and arranges to see ophthalmologist re eye injuries **'to try to put together a coherent account from the health service at the case conference.'**

16.05.00 **Kennedy seen in A&E when mother admitted with seizure. 'quiet but able to walk round'.**

17.05.00 **Kennedy brought in cardiac arrest with fixed dilated pupils. Resuscitated but pronounced dead later in ITU.**

Post mortem carried out by Professor Anthony Busuttil and Dr. Jean Keeling established cause of death as complete hyperextension type injury to the lower thoracic spine involving the intervertebral disc between T10 and T11 with complete separation of the two sides of the disc and extensive haemorrhage on both sides of the injury. There was no external corresponding injury on the skin of the back. This injury will have led to immediate shock and brain swelling leading to loss of consciousness and subsequent brain death. There was also recent bruising to the scalp, over the crown of the head, the back of the head and over the forehead, extending as far as the outer surface of the skull (periosteum) indicating other episodes of injury occurring earlier. There was some linear bruising of the back. Marked congestion particularly of the right eye is noted. Analysis of samples for toxicology showed the presence of diazepam in her blood and ibuprofen in her stomach at the time of death.

Cause of death recorded as blunt force trauma.

Comment on the roles played by health professionals

These comments are based on a reading of all the available records (including the audit reports) together with the facts, views and opinions of staff gathered during the interviews of the key professionals, and discussions with the Reference group.

Health professionals interviewed were as follows:

Con. Paed 1-Consultant Paediatrician, lead clinician child protection
CPA-health- Child protection advisor – health (nursing background)
HV-Health visitor
GP-General practitioner
WS1 and WS2- ward sisters

Primary care team.

Hair loss and recurrence of soiling are early indications of emotional distress and, in my view, should have been identified as highly concerning if seen in the context of the playgroup's reports of her dramatically changed demeanour and physical presentation. All this information was available to the health visitor and at least some of it shared with the social workers SW. and PSW. This information was not shared with Con Paed 1 prior to the planning meeting.

The GP suspected a UTI the first time Kennedy presented with a sore back. Even in the absence of other symptoms or signs this is reasonable on the first occasion but perhaps one would have hoped suspicions might be raised when this became a recurring complaint in the absence of proven infection and in the presence of so many other unusual complaints. It is particularly relevant given the case of death and suggests there were previous non-accidental back injuries. Again however it is such an unusual presentation of child abuse that missing its significance as a presentation if taken in isolation is not surprising.

Hospital team

There is a lot of evidence of health colleagues tending to assume other people (within and out-with health) are taking appropriate actions and not checking/discussing/ following up. In addition, health professionals (particularly Con Paed 1) left inexperienced and inappropriate staff to take responsibility for actions e.g. CP nurse advisor clarifying ophthalmologists findings and opinion, junior staff asked to check toxicology results, social worker asked to contact clinical psychologist.

It does seem surprising that an experienced paediatrician (a different consultant on this occasion) would accept the explanation of the swing for unwitnessed injuries to the front and back of a child particularly given the previous concerns documented in the notes. Mother could really have brought in a photograph of almost any piece of furniture or plaything. Perhaps the very fact the mother should feel it necessary to bring the picture

might have raised suspicions. One might have expected more caution particularly when the child was not his patient. This raises a question about the understanding within the team of the role of the lead clinician, child protection, if this can happen? Once the toxicology results came back showing that Kennedy had ingested carbamazepine, an anti-convulsant prescribed for her mother, it might have been expected that he would then recognise the risks to Kennedy, reconsider his decision to discharge her, and recall her immediately rather than simply request follow up a week later.

In her interview Con Paed 1 made it clear that she takes full responsibility for the decision to discharge Kennedy on 05.05.00, following discussion with CPA and in the knowledge that the need for a CPCC had been agreed. Although she had major ongoing concerns about Kennedy it was her understanding that TM and PSW were happy that she should go home in the interim and she trusted their judgement. This appears to have been quite a hurried decision on her part (due not least to a number of other very concerning child protection cases on her mind at the same time) and was influenced by the fact that she was going on holiday. Unfortunately despite the high level of concern felt by the paediatric team there was no clear health or inter-agency follow up plan perhaps because all the staff expected the case conference to be held rapidly. Con Paed 1 did not directly inform social workers of her decision to discharge Kennedy. They received notification 4 days later.

I remain unclear as to why Con Paed 1 did not pursue and clarify results herself and write a clear report for the planning meeting, or indeed subsequently, in the expectation of referral to the reporter following the CPCC. It is clearly not appropriate for a nurse advisor to seek or be expected to seek clarification of medical information from the eye consultant.

It is also unclear how much of what happened/didn't happen at this stage was because of the family's attitude, diverting people from the main issues so that professionals were not clearly focussing on Kennedy's needs.

If there was a further eye injury at follow up on 5.5.00, and subsequent discussion with the Eye Consultant by PSW appears to confirm that there was, (although on this occasion it was less severe healing quickly within 24 hours), this is very important in terms of the overall evaluation of the case, and should have been flagged up to social work. This finding plus the observation of ongoing congestion of the eyes at post mortem suggests that Kennedy was subjected to repeated eye injury, and it remains unclear who perpetrated this.

Why was there to be such a long delay to CPCC. Social work colleagues assert that this was in order that cons.paed.1 could attend and the date was one offered by her secretary in discussion with her. Given the particular importance of medical evidence in this case it was clearly inappropriate to have the CPCC without the lead paediatrician. No attempt appears to have been made to change the date was made once it became clear she was unlikely to be able to attend.

It is clear that there are major problems within the paediatric team with three very different responses to suspected child abuse and neglect. It is also clear that this had been drawn to the attention of the Trust and health board. There is also evidence to suggest that Con.

Paed 1 is over reliant on CPA to advise on identification of risk and case management. This is highly inappropriate given her nursing not medical background and relative lack of experience. Con Paed 1 also appears to place too much reliance on TM for decision making and appropriate action.

It is however equally clear that some very good work was ongoing setting up referral pathways, training programmes and support to less experienced nursing and junior medical colleague. This was being led by CPA and TM and involving PSW and ward sisters and community based colleagues. It continued to be hindered to some extent by difficulties arranging input from the consultant paediatricians.

2.6 Social Work Involvement

Summary of main events

28.01.00 Referral from playgroup, noting marked decline in Kennedy's physical appearance since Nov. 99, and mother's very negative attitude towards her wetting, and noted to smack her bottom and legs. TM decides to treat this as child care and not child protection.

14.02.00 Telephone discussion with health visitor recorded in social work files

15.02.00 Home visit by FSW SW after letter sent to family. Issues discussed not detailed in case record but playgroup's serious concerns not clearly shared. Focus clearly around mother's problems and not on Kennedy. No formal assessment of Kennedy was undertaken. Kennedy noted to be grubby in comparison with other children who seemed much smarter. The house was reported to be clean. Mother declined any practical help and indicated that social work should not visit again.

? date **SW** discussed the visit with TM. TM asked her to feed back to playgroup and ask them to feed any further concerns back to social work. TM felt there were unresolved concerns. Phoned HV, no specific concerns but no recent contact. SW seem to accept the fact that 9 year old brother acting as carer when mother ill. Established that Kennedy not unhappy at playgroup, not interacting with TD but not appearing frightened of him.

03.03.00 Supervision discussion between SW and TM. Case to be closed after liaison with HV and advice to family about the young carers group. No formal record of outcome of assessment.

03.03.00 Later on the same day. SW first made aware of eye injuries. (day of admission). Referral from hospital initially to PSW. She made hospital staff aware of SW previous involvement and referral passed to TM. No evidence that a referral form was completed. TM notes lack of clarity re causation because of differing medical opinion. Did not think this was necessarily CP and no formal assessment initiated. No discussion with the police. TM apparently of the view that it was the role of the medical staff to ascertain how the injury occurred before a decision could be made about the necessity of a CP enquiry.

5.3.0 Kennedy discharged by the paediatrician following discussion with the ophthalmologist. TM surprised because the explanation was still inconsistent with the injuries but no specific actions to address this appear to have been taken. PSW also noted to be unhappy but again took no remedial action, although she did continue to consider the possible explanations at subsequent contacts.

23.03.00 Further referral from playgroup received initially by PSW. Bruising across most of Kennedy's cheek. Kennedy very wary of Thomas Duncan when he collects her from playgroup, and ongoing concerns round wetting and soiling. Information faxed by PSW (who was clear this was a child protection referral) to (TM). PSW also telephoned. Records again incomplete in relation to child protection forms but the referral appears to have been recognised by TM as child protection. However no formal investigation was initiated i.e. police were not informed and no medical assessment was requested. In SW's absence on leave SW1 and SW2 (duty social workers visited the following day 24.03.00. The workers did not access the case file which was available in the office and were therefore not aware of the extent of previous concerns. SW2 has stated to PSW that they did not have full details of the referral (contained in her fax) either but took a 'fresh look' at the case. They accepted grandparent's explanation of the injury and mother's explanation of the playgroup's concerns. Subsequent discussion with the manager led to no further action being taken or planned despite her knowledge of the previous concerns. No CS002 was completed.

27.04.00 SW team not informed re carbamezepine ingestion and Con Paed 1 concerns until 27.04.00. when the 'To whom it may concern' letter from Con Paed 1 dated 25.04.00, arrived in PSW's mail tray detailing her concerns following her discussions with Kennedy's mother and her readmission to the ward on 24.04.00. In this letter Con. Paed 1 makes it clear that she feels Kennedy is at risk and that she expects multi-agency involvement. She highlights the vague and changing stories accounting for Kennedy's injuries and presentations. CP referral form CS002 started by PSW but not typed up until after Kennedy's death on 17.05.00.

28.04.00 Planning meeting. Very short and constrained by presence of mother and Thomas Duncan. Issues clearly identified but no clear actions to address them and no contingency plan for Kennedy's care until enquiries complete. Agreed that Kennedy would be discharged when medically fit. No dissenting views are recorded. Mother and Thomas Duncan agree to co-operate with further enquiries. Still no plan for formal joint investigation with police, or referral to the Reporter. No multi-disciplinary care plan formulated .

03.05.00 Home visit by FSW and PSW to carry out further inquiries including interview with siblings. Further discussions with team manager lead to decision to hold case conference and refer to Reporter although the thinking behind this at this stage is not recorded in the file. Documentation subsequently completed based on PSW's typed information for the CS002 shows that the information on initial assessment of risk and action taken for immediate protection of the child/children provided by PSW has been omitted from the official form without her knowledge or agreement. **The final version fails to highlight the extent of known concerns for Kennedy's safety or the lack of a clear plan to investigate her circumstances or to protect her while the case conference is arranged.**

04.05.00 Mother and Thomas Duncan told of decision to hold CPCC, very angry and upset.

04.05.00 Telephone discussion with GP. GP raises concerns about number of contacts with health centre since January and possibility of Munchausen by Proxy raised. He states that he considers her to be at risk.

05.05.00 Visit to Kennedy's natural father and great-grandparents SW and PSW. Information obtained from them indicating that Kennedy scared of Thomas Duncan. The family did not however share the very serious concerns about ill treatment of Kennedy which they shared subsequently.

05.05.00 Indications that they were withdrawing their co-operation with enquiries. Health unaware of this change.

05.05.00 Kennedy discharged. The timing was not discussed with SW although SW had been at the hospital earlier in the day. The PSW had understood further toxicology results were awaited. Social workers did not find out she had been discharged until 09.05.00. However TM felt there would have been inadequate evidence for a child protection order, but did not discuss this decision with senior social workers or medical colleagues or test it in discussion with legal colleagues/Reporter.

There was no further social work contact with the family prior to Kennedy's death despite the level of concern acknowledged by the team by this stage. No efforts were made to check on her well being eg through the health visitor.

Comment on the Role Played by the Social Work Professionals

These comments are based on a reading of all the available records (including the audit reports) together with the facts, views and opinions of staff gathered during the interviews of the key professionals and discussions with the Reference group.

Social Work Department Professionals interviewed were as follows:

TM- team manager, short term assessment team
FSW-family social worker
PSW- hospital paediatric social worker
OM-operations manager
CPO-child protection officer-social services
LSM-legal services manager

DR-a Divisional Reporter on behalf of the Childrens' Hearing Service in Dumfries & Galloway:

Failure on the part of social work staff to complete the forms required in child care and child protection is a repeated and very concerning finding in this case. Whilst it may be felt that this does not necessarily imply that the appropriate information was not gathered, shared and considered in moving forward, it makes it impossible to check that. In my opinion there is a clear lack of methodical investigation and analysis throughout this case particularly at team manager level. Clear procedures with appropriate standard documentation are in place in D&G to promote communication and allow case monitoring and audit and should have facilitated good practice.

Absence or delay in their completion in this case is very concerning although there is of course no guarantee that if the forms had been properly completed different decisions would have been made leading to a different outcome. The implications of the omission of PSW's risk assessment from the CS002 typed up (on the day Kennedy died) and screened by the planning and assessment team is very serious and requires review by the line mangers. The level of concern indicated in this final version bears no resemblance to that expressed in PSW's original draft. It also implies that an agreed multi-disciplinary child protection plan is in place which was not the case. PSW was clear in her interview that she had flagged up her increasing concerns for Kennedy's safety to TM and thought that they were shared by TM and her colleague FSW.

All the professionals interviewed shared a lack of clarity about the procedures and decision making in relation to the case, particularly at the early stages. Was it a child care or child protection referral? It is clear that the referring agencies, playgroup staff and paediatric social worker PSW and the paediatrician regarded it as child protection. Certainly in the

referrals relating to the eye injury and the drug ingestion concerns re child abuse and the need, in the paediatrician's view, for multi-agency involvement is specifically documented.

The team manager took the decision not to request joint investigation on these occasions although D&G guidance, in keeping with Scottish office guidance ref (3) part 4 page 24 para 4.8, makes it clear that information from the relevant agencies including police, health and education services should be sought even in referrals which are not deemed to require an immediate response. Once in receipt of all relevant information it is certainly the social work department's statutory responsibility to decide what to do next, but it is also clear that any further inquiries should follow a discussion with the other agencies **including police** who may wish to undertake a joint investigation. Paragraph 4.10 states "**in cases where the level of concern is sufficient to warrant consideration of child protection procedures the social work service must consult with the police"**

There is also a lack of clarity about how to access medical opinion where injuries, or the clinical state of the child, are concerning but not clearly non-accidental in origin. There is a need for a route to preliminary medical assessment by general practitioner or community child health doctor to give a qualified opinion on the nature of bruises and whether or not they are consistent with the explanation. This is outwith the competence of social workers who also have no authority or reason to ask for the child to be stripped so that other potentially more serious injuries can be observed. The new Scottish Executive Guidance for Health Professionals (3 page 36) terms this a 'comprehensive medical assessment' reminding workers of the importance to consider the child's overall condition including emotional well-being and development in considering evidence of significant harm resulting from ill treatment or neglect.

In response to the playgroup's anxieties about the family knowing that they had contacted social services, TM decided to treat this referral in a 'low key' way and FSW visited having sent a letter which referred to the mother's own needs for help the previous year. FSW informed me that she was not even aware of the full details of the concerns raised by the playgroup and certainly did not explore them with the family. In addition, the fact that "lack of fear" was taken as reassurance together with assertions from FSW even with the benefit of hindsight, "that an experienced worker can recognise abuse on a home visit and tell if a child is at risk" are very worrying. In contrast therefore to the D&G interagency advice that 'sensitive honesty in the long run is more likely to provide the basis for a positive working relationship's (CPC 1998) page 9 this referral was inadequately explored because of the attempt to maintain the anonymity of the referrer. Thus the very real and ultimately highly significant concerns about Kennedy's general physical and emotional wellbeing were not recognised and their significance was missed in subsequent inquiries.

Health and social workers were unclear in moving into the planning meeting whether this was an informal preliminary CPCC, a pre-referral sharing of professional concerns or a meeting of professionals to plan ongoing child protection investigations. As a result they were confused about its status, whether or not parents should be allowed to attend, or indeed if they could be excluded. This confusion, together with the hostility of the parents, in my view led to a meeting which was neither effective in sharing fully the serious concerns

which were recognised by, it seems, all but the team manager, nor effective in evaluating the factual medical evidence which was available by that time. Nor did it result in a clear action plan. As a result the agreement was reached that Kennedy could be discharged when medically fit while inquiries continued but with no clear plan for that investigation and no explicit plan to protect her in the interim. Social services were not even aware of her discharge for four days!

It is hard to understand why given the level of concern felt particularly by health colleagues they did not challenge this during or after the meeting. It appears even more remarkable that the team manager did not feel that there was enough concern/evidence of harm to justify a CPCC. Even the brief minute of the meeting, which participants say does not fully cover the discussion, seems to record enough concern to trigger full joint investigation and case conference. It seems perhaps surprising, and unwise, for TM to take that decision regardless of these concerns even if she did not personally share them. If however it is the case that colleagues relied on her to make that judgement and did not trust their own analysis of the situation feeling her to be more senior and experienced it may be that they did not adequately register their own views and opinion. This of course is a training issue in relation to joint working and team working in child protection particularly in relation to referral discussions, chairing of meetings and joint investigation.

As a result subsequent inquiries lacked direction and co-ordination. Workers allowed themselves to be side-tracked onto details e.g. whether Kennedy could have opened pill bottle, whether brother could have injured her during sleep walking. They persisted in futile pursuit of these even at stages when further information was available which refuted these explanations, and they failed to recognise the overall picture of escalating concern.

It seems remarkable that the team manager never mentioned the Kennedy case to her line manager OM in their monthly supervision sessions although a number of these were cancelled due to 'pressure of work'. Both SW1 and TM are clear that if she had wished to seek advice it would have been readily available from a number of sources including the legal department.

Although the Child Protection Advisors from Social Services and Health share an office this does not necessarily appear to have improved working together between the agencies and might indeed have led to some ambiguity about the roles. It seems remarkable that they could have shared an office over what was clearly a very anxious time for CPA without the case being explicitly discussed and guidance sought. The child protection officer for social services CPO clearly has an important responsibility in keeping the Child Protection Committee informed about current working practices, facts and figures of referrals and outcomes. It would seem that further thought about the meaning of the numbers of children referred, registered and on supervision orders compared to the rest of Scotland is needed, in as much as it reflects on current practice particularly relating to thresholds.

Senior managers within SW services in D&G having now been over all the collated information clearly acknowledge that formal investigation including police referral and the calling of a CPCC should have taken place earlier. Unfortunately the team manager at the

time did not recognise this need despite the attempts of colleagues to highlight their concerns. On a number of occasions she personally decided not to progress a referral as child protection although other experienced professionals regarded it as such. Even after the planning meeting it was her view that a CPCC was not justified. She seemed to feel that this and other major decisions about the case were hers to make without the need to seek support or guidance from senior more experienced colleagues. However she was clearly hindered by the lack of clarity about the medical evidence from the health team. It is also unfortunate that others did not challenge these decisions. This was certainly, in my opinion, at least in part due to their confidence in her as a practitioner. It may also reflect personality issues and a lack of understanding by other professionals in both agencies about their responsibilities within the procedures and of legal remedies in relation to protecting children.

Lack of involvement of the Reporter, and a continuing view that this would not necessarily have offered any assistance in moving forward, is of note. It seems to suggest a difference in practice from other areas where, certainly in my experience, early discussion with the Reporter in complex cases can be very helpful. Frequently it helps to ensure the very systematic and careful analysis of information required for a thorough risk assessment if this has not already been completed through effective interagency working. Some of those interviewed have suggested that locally the Reporter's department would not be seen as a likely source of helpful direction in a difficult case. If this is the perception this should be explored as another working together/training issue. The Reporters Office has made it clear to the inquiry that they welcome early discussions in complex cases to explore the way forward.

The information from the Reporter's office indicating the very low numbers of cases going to proof of grounds of referral before the Sheriff, particularly in relation to physical injury, is extremely surprising and very out of keeping with my own experience in a mixed small town /rural population of similar size in West Lothian. It seems to suggest that grounds of referral relating to lack of care are used and accepted by parents which could however compromise the protection of the child and siblings in the longer term if evidence relating to significant physical injury is not tested. It also means that the paediatricians are not experiencing the challenge of preparing and presenting evidence in Court which in itself is an important learning experience and informs good practice. The Child Protection Committee is likely to wish to explore the reasons for this difference in practice.

The serious problems in the management of this case occurred despite the presence of clear interagency procedures and documentation, particularly referral forms, to support them. In addition regular supervision, or in its absence ready access to managers, and advice from experienced colleagues in legal services is available, and the process of review of the referral form (through planning and assessment) requesting a CPCC should have provided another check. Unfortunately however if advice is not sought and forms are not filled in timeously or if vital information on risk assessment is missing these checks and balances of professional performance cannot come into play.

2.7 POLICE INVOLVEMENT

These comments are based on perusal of all the available reports, (including the audit reports), and an interview with the Detective Inspector for the Family and Child Unit in Dumfries and Galloway.

Comment on the role played by police

Police involvement was not sought until Kennedy's death. This seems to he been because the senior worker TM never felt the threshold had been passed to trigger a joint investigation. Even subsequent to the child's death some social work colleagues remain of the view that they would have had little to offer earlier on. **This attitude is disappointing given the emphasis on joint working. Senior managers within D&G do not share the concerns expressed by some case workers about the quality of police involvement and perhaps were not aware of these potential difficulties in working together.** DI-FPU, interviewed on behalf of the police, informed me that the police particularly in the family protection unit, welcome informal discussions and early referral even when it my be agreed that they do not need to be immediately involved in an investigation.

In Kennedy's case, DI-FPU felt that the police would have been able to check whether the cohabitee was known to them, and would have been able to enquire into the circumstances of the eye injuries and drug ingestions. They would almost certainly have been able to help expedite the exclusion of some of the explanations even if not clarifying the actual circumstances. The police would also have identified the lack of safe storage of drugs despite the mother's assertions. The great grandparents and natural father may also have been more forthcoming about their concerns within the context of a formal inquiry.

After Kennedy's death a police search revealed many prescription drugs in insecure containers. Another relevant finding was soiled pants in bin. On the day of her death Kennedy was described as suffering diarrhoea and her resulting distress and increased care needs may have been a factor in triggering her assault.

2.8 Information about the family

Appendix (b) details the family members and relationships.

Vicki McFarlane was separated from Kennedy's father Chris McFarlane who had regular access visits. His grandparents, who brought him up, also cared regularly for Kennedy (including overnight stays at weekends) mother welcoming the break. Kennedy's two half brothers lived with her and her mother, but the only other female child, a half sibling lived with her natural father. Thomas Duncan had joined the household in November 1999 and it was since then that nursery had noted a marked decline in Kennedy's care and well being.

Subsequent investigation has produced a lot of information about the problems within the family, the mother's health etc which would have been very relevant to the risk assessment and planning for Kennedy and was available to be gathered at the time if a full investigation in line with child protection procedures had been triggered.

Initially Kennedy's mother was plausible and pleasant, appearing concerned for her daughter and always coming up with explanations. Subsequently she and the partner Thomas Duncan were described as verbally aggressive and uncooperative particularly once told of decision to hold Child Protection case conference. However the degree of anxiety felt by staff in handling their hostility does not appear to have been a major factor, and I have not found the suggestion that staff feared for their physical safety and that this compromised their work borne out in interviews with case workers.

3. OVERVIEW ANALYSIS

It is clear from the available information that, as in previous tragedies of this nature, no single person or agency was to blame for Kennedy's death.(4) I am in no doubt from my own enquiries and those of senior colleagues within the agencies in Dumfries and Galloway, that all the staff involved did their best in difficult circumstances. I do not believe that anyone could have predicted the sudden and violent death, which occurred on 17.05.00, although in retrospect back pain is a very unusual presenting symptom in a three-year-old and she was presented three times within six weeks.

However a number of opportunities for more effective intervention did arise as the case unfolded and one might have reasonably expected that experienced professionals in both health and social work would have acted differently. If the senior staff in either agency had **carefully reviewed all the information available in their own records** certainly by 24.04.00 (changed physical care and demeanour, soiling, repeated bruising, eye injuries and poisoning) and probably even by 4.03.00 (eye injuries) **it should have been clear that at the very least Kennedy's care was inadequate to protect her from significant harm, even if it was not clear that she was suffering deliberate ill treatment**.

It is my view that if any one of the senior professionals in health or social work had recognised the seriousness of the case and taken a clear lead the outcome could have been very different. Even if he or she felt that the other colleagues were not responding effectively other alternatives were available to trigger a formal multi-agency child protection investigation. For example I cannot understand why the police were not involved until Kennedy was dead. Referral to the police of any child where abuse or neglect is suspected by any agency, or indeed a lay person, is always an option, as is direct referral to the Reporter to the Children's Hearing. I find it particularly remarkable in this case that the police were not involved until Kennedy was dead.

Sadly however there is no evidence that any individual in this case felt frustrated enough by the actions (or in-actions) of others to search round for other ways to flag up Kennedy's plight. The possible exception being Kennedy's mother who may have been trying to do so in returning to the ward unprompted on 24.04.00. As is so often the case, no-one put **all the pieces of the puzzle together creating a total picture of escalating harm within a context of a family in need. If they had done so I am in no doubt that she could and would have been protected.**

No-one asked the questions: What do we know about this cohabitee? Why have concerns about Kennedy's care and her presentation with unexplained injuries and symptoms all occurred since he joined the household? What do we make of the comments about Kennedy's relationship, or lack of it, with Thomas Duncan? What is the origin of the soiling and the hair loss? Equally no-one appears to have wondered why the older daughter no longer lives with her mother. Is this an indication of yet another factor placing Kennedy at risk? What are the implications of mother's own health problems for Kennedy's care? Is it acceptable that a nine-year-old boy be seen in the role of carer for this young and needy family if his mother takes ill?

Accepted good practice in child protection interagency procedures, (and those in place in Dumfries and Galloway, even prior to the most recent practice note on the referral process, are no exception), should have led at least to a discussion with senior police colleagues experienced in child abuse work at each point of referral. Even accepting that the initial referral from the playgroup (28.01 00) might have merited further exploration before proceeding, the subsequent referrals from the hospital should have triggered such a discussion particularly the one on 24.04.00 coming from a senior consultant paediatrician with the lead role in child protection. Even acknowledging that the health information that was shared was not as detailed as that available to the various health professionals, given the background information already available to the social work department by that stage **there should have been no doubt in anyone's mind that this was a child at risk of serious harm and requiring immediate protection while a full investigation and risk assessment took place.**

The new advice, issued by Dumfries and Galloway CPC on 01.12.98, introduces a clearer framework to the initial referral stage of the process but still seems to leave it to the team managers' discretion to determine whether the child has suffered or is likely to suffer significant harm, without clear criteria for that decision making. **The team manager asserted on a number of occasions that she needed clear medical evidence of non-accidental injury to proceed to joint investigation. It is of course the process of joint (multi-agency) investigation which is intended to gather the evidence to provide the proof, and therefore to fail to proceed except in obvious cases of abuse must leave children at risk, particularly of harm through inadequate care and deliberate neglect**. This also fails to recognise the vital contribution particularly from the police component of the investigation.

In trying to make sense of why a full multi-agency investigation was never initiated a number of questions and issues emerge:

1) Why was the medical information not gathered, collated and interpreted effectively so that it could be used to trigger an appropriate interagency response?

Social work, police and legal colleagues are dependent on paediatricians and forensic physicians to present the medical evidence effectively if they are to protect the child particularly in cases like this where the health concerns are high and would form the major part of the evidence required to sustain any subsequent legal proceedings. There seemed to be a lack of appreciation of this responsibility within the health team even suggesting that social work colleagues sought clarification of important results or a psychology opinion. It is clearly the responsibility of the lead paediatrician in child protection, who also in this case had direct clinical responsibility for the child, to gather the medical information and form an opinion on its significance for non-medical colleagues. (Con Paed 1 was clear at interview that these were indeed her responsibilities). The failure to achieve this suggests a lack of adequate training in evidence gathering, and interpretation of medical facts and

findings from the paediatric and forensic point of view. This knowledge is essential to underpin the skills of report writing, interpretation and presentation of medical information to professionals in other disciplines and agencies.

It was unfortunate that Kennedy's presenting conditions were not typical of non-accidental injury. However in the face of such a series of unusual and inadequately explained signs and symptoms it might have been expected that the paediatricians would have sought further expert opinion on the medical evidence, particularly the eye injuries and the poisoning. It is in my view to miss the point to say that the medical literature does not indicate that this is an injury likely to be non-accidental in origin. The important point is that bilateral corneal abrasion is a serious and rare injury and in the absence of a clear accidental explanation and the seeking of prompt medical care non-accidental or neglectful causation must be strongly suspected as in any other serious unexplained injury. Again early **involvement of the police in investigating** the exact circumstances round these presentations, e.g. visiting the park and the home, interviewing the carers, would have assisted greatly in clarifying these events and highlighting the inadequacies of the explanations. It is also likely to have led to the seeking of forensic medical input.

2) Why was there such confusion over the Child Protection process in this case?

Given the stated levels of training and experience of the involved staff, the clear guidance (agency specific and interagency) which is in place and close partnership working between the Health Trusts and the Local Authority this is perhaps surprising. In particular why was there so much debate and uncertainty about whether there should be a **planning meeting rather than a case conference,** whether parents should be allowed to attend, and what should happen next? Why did the professionals fail to draw clear conclusions at the end of that meeting and make a plan that would protect Kennedy? **Why was there still no plan to initiate a formal interagency child protection investigation, including the police and informing the Reporter? The need for urgent risk assessment and a plan to protect Kennedy while this was undertaken was not clearly identified by any of the workers either at the time, through the subsequent file audit or spontaneously at interview, even with the benefit of hindsight.** At the time of Kennedy's death even though TM had agreed to a CPCC and referral to the Reporter there was no clearly documented plan of investigation and the workers still appeared to be at a pre-referral stage of assessment. This is of great importance as it was continuing to impede their investigations (e.g. discussions with natural father and his family which were carried out in the context of information for the Children's Hearing) and almost certainly affected their thinking in relation to risk assessment and intervention.

Despite the well evidenced training programmes and detailed guidance to staff, and the observed commitment and enthusiasm demonstrated at interview by particularly CPA and TM, a lack of clarity and understanding about procedures, responsibilities

and legal solutions is obvious at all levels among the health and social work staff involved and must impact on other cases. It was clear at interviews with the staff that they see the decision whether or not to hold a case conference as the team manager's to make, albeit with the 'quality loop' through the care planning and assessment team. Both D&G and Scottish Executive interagency guidance (2) emphasise that whilst it is the responsibility of the social work department to arrange and chair a CPCC any agency can request a case conference which should be held if 'a case requires interagency discussion and planning' (protecting children page 31 para 4.3.) as this case clearly did. This section also clearly outlines the objectives of the conference. Although the action to be taken if there is disagreement on the part of social work about the need for case conference is not explicitly stated, the whole tone of the document is to encourage collaboration and joint working and it would seem unlikely that social services should feel they have the power of veto. This raises serious questions about whether those offering training and managing field workers are themselves experienced enough to carry out these tasks effectively, and whether they are receiving adequate support and supervision in this aspect of their work.

3) Why was there such a failure to work in partnership with other agencies?

There seem to have been major problems with joint working, particularly an absence of joint decision making and even a failure on the part of the senior social worker to perceive that joint decision making was either desirable or required. Agencies need to be clear that any decision **not to proceed with a child protection investigation** when any agency or individual makes a clear referral mentioning non-accidental injury, abuse or neglect needs to be made jointly, and only after background information available to each of the three key agencies, Health, social services and police has been gathered and shared.

Equally agencies need to be confident that factual information/evidence which is available is fully understood, and its relevance to the assessment of risk evaluated by a professional experienced in child abuse. Any member of the team needs to feel able to ask for clarification of the factual information and its interpretation, or to request the involvement of other experts. For example an ophthalmologist working in a District General Hospital is unlikely to have much experience in the interpretation of non-accidental injury even in respect of eye injuries, and therefore the paediatrician with lead responsibility must take responsibility for ensuring that this medical information is fully evaluated seeking expert opinion, forensic, paediatric and/or ophthalmological, from elsewhere as appropriate. This would equally apply to orthopaedic or neurological opinion in other serious circumstances. Similarly the interpretation of the toxicology results in this case is another example of the need for the lead paediatrician to seek expert help in interpreting the significance of the results in terms of time frames, likely quantities etc. He/she should have felt able to clearly indicate to the social worker, particularly by the time of the planning meeting, that the child's well-being and potentially even her life were in danger as a result of poisoning.

Key players in this case all seem to have made assumptions about each other's actions and responsibilities without always checking these out. Most crucially, staff on the children's ward accepted the statement by social work that Kennedy should be discharged when medically fit without challenge, despite clear indications, particularly in the nursing notes at that time, that they were unhappy with that decision. This led to her discharge on 05.05.2000, and was the last time she was seen by any health professionals before her final admission with fatal injuries.

4) Why was there so much uncertainty about the legal procedures?

Medical staff, including the consultant paediatrician completing the health audit in his overview, seem to feel that **irrefutable evidence** would have been needed at the planning meeting or case conference to secure Kennedy's protection. If that were indeed the case many children would remain in dangerous and neglectful situations, and much interagency working would be in vain. Many of the cases dealt with on a day to day basis in the context of the Children's Hearing system in Scotland relate to children where it is a **lack of care which leads to an unacceptable risk of significant harm rather than deliberate ill treatment,** or situations where non-accidental causation is established but it is unclear who is the perpetrator and criminal proceedings are not invoked. Such cases are successful where meticulous gathering of the facts and effective interpretation and presentation before the Sheriff establish on the "**balance of probability that the child is likely to suffer unnecessarily or be impaired seriously in her health or development due to a lack of parental care if compulsory measures of care are not put in place". (5)**

It is clearly vital that all senior colleagues working in child protection have an understanding of these basic principles and processes. In cases of complexity it is very helpful to take the opportunity to discuss the facts and concerns at an early stage with the Reporter, the Procurator Fiscal or the departmental legal advisors. It is important to remember that it is the Fiscal who is ultimately responsible for the gathering of the best medical evidence in situations where a crime may have been committed, and the Sheriff who determines whether or not there is enough evidence to grant a child protection or child assessment order and it is not the job of social workers or indeed doctors to best guess the outcome. It seems likely that if this case had been discussed at any stage with the Reporter care proceedings would have been instituted and certainly in response to the final referral in April 2000. It also seems almost certain that if all the medical evidence and social/developmental concerns had been collated and presented to the Sheriff on 05.05.00 (when the parents co-operation was withdrawn- at least in part) an order allowing Kennedy to be protected whilst a joint investigation was completed would have been granted.

A Sheriff may grant a Child Assessment Order under section 55 allowing for the assessment of a child's state of health or development or of the way in which he/she has been treated 'if he is satisfied that there is **reasonable cause to suspect that**

he is suffering or likely to suffer significant harm.' A child protection order may be granted under section 57 'where a Sheriff is satisfied that there are **reasonable grounds to believe** that a child is being so treated (or neglected) that he is suffering or will suffer significant harm if he is not removed and put in a place of safety.' Neither therefore requires irrefutable evidence of deliberate ill treatment to have already been obtained.

I accept that the granting of a child protection order on the basis of the information available on 05.05.00 may not have secured Kennedy in substitute care for a lengthy period without the gathering of further evidence of abuse or neglect. However it is my view that once a detailed investigation and risk assessment had been undertaken collating all the information available to the different professionals involved in her care, in particular bringing in the evidence from the natural father's family, and including the episodes of back pain, the full picture of escalating harm would have come to light with major concerns about mother's as well as the cohabitee's care and there would have been adequate grounds to ensure her ongoing protection.

In summary:

I am still not entirely clear why, despite the recorded concerns (over a period of several months) and the commitment of health and social work colleagues to Kennedy and her family, child protection investigations and intervention did not get past the referral stage and Kennedy therefore remained unprotected. It is likely that many factors were involved :

- Problems with the clarity of medical evidence discussed elsewhere in this report were clearly very important.
- Inappropriate reliance on the opinions and advice of others was clear at a number of stages
- Overconfidence in the decision making by/of team managers, and a failure to recognise the need to introduce checks and balances by testing their thoughts and plans against the opinions of others more experienced than themselves. It is not clear whether this is an individual problem or organisational.
- Unchecked assumptions about the involvement and views of others eg social work assumption that the HV would visit weekly to monitor and 'protect', Con Paed 1 assumption (based on what CPA allegedly reported to her) that if TM thought it safe for Kennedy to go home it would be.

4. CONCLUSIONS and RECOMMENDATIONS

4.1 Local

Having carefully considered all the information made available during the course of the inquiry, it is my opinion that this was an avoidable child death.
It is equally clear that no one individual was at fault nor a single agency ultimately responsible for Kennedy's death. However the two lead workers, the social work team manager (short term assessment team) and the consultant paediatrician, (lead clinician child protection), were in the positions of case work responsibility and inevitably therefore had the greatest opportunity to effect the outcome. The question has to be asked however why such experienced and committed staff made so many basic errors and why managerial oversight along with the systems and procedures in place failed to detect them.

It is my opinion that a senior social worker of the experience and training of this team manager should have recognised the extent of the ongoing risks to Kennedy McFarlane certainly by the time of the planning meeting, and that even if the medical evidence were not collated and presented in an ideal way by the Consultant Paediatrician, making the risks absolutely explicit, the level of concerns being raised by so many colleagues should have been enough to trigger a formal joint investigation and an interim child protection plan. Although this failure on the social worker's part seems to have been out of character, and indeed one of the contributory factors has been the trust which other professionals have placed in her opinion, it was in my view serious and the reasons for it require to be addressed. Her confusion over planning meetings, parents involvement and failure to seek legal advice before asserting that there were no legal grounds to hold Kennedy also indicate the need for further training and closer supervision. Although workload issues were not highlighted in relation to this worker by my enquiries, the Reference Group recognise that **work pressures were a significant factor for the social workers in this case**, and arrangements for their review of critical importance in relation to all staff involved in child protection.

Similarly it is my view that the **lead clinician is currently out of her depth in relation to child protection cases**. There are a number of clear contributory factors to this, lack of specialist training or support in this area of work, a very difficult dynamic within the team of three consultants in relation to child abuse (which had already been brought to the attention of the Trust and Health Board and is continuing to adversely affect child protection cases in the ward), and a totally unrealistic work load. As a result the medical evidence in Kennedy's case was not effectively collated and presented to social work or at the planning meeting and this is likely to have contributed to social work's failure to recognise the risks. There is no doubt that this doctor is a caring and highly regarded paediatrician but there are only 24 hours in a day, and child protection is probably not an area of work she would choose to specialise in.

As my inquiry has progressed it has become increasingly apparent that not only were there significant deficiencies in the individual responses of health and social work staff to Kennedy's needs but that the difficulties experienced in working together in relation to cases

presenting to the ward were particularly acute. It is clear that these do not only relate to this case but have been present for some time and are ongoing. As a result the handling of Kennedy's referral was in my view affected adversely by the context of lack of trust/confidence felt by the social work team (particularly its team manager) in the consultant paediatricians. **All those interviewed** (except the junior sister) **recognise the difficulties within the consultant team in relation to management, referral thresholds and effective gathering and sharing of medical evidence. There is no doubt that this is impacting negatively on the service children receive from the Trust.** Whilst one might hope that the recognition of his situation would lead to added caution in evaluating cases erring on the side of protecting the child until the situation is clearer, it is never the less easy to see how it may have the opposite effect. In other words TM was reluctant to pursue matters until she had clear evidence in writing indicating that Kennedy was at risk. TM's frustrations with working in this situation were very obvious at interview and she and CPA have worked hard to address the difficulties, setting up ward meetings, training programmes etc. Senior social work managers were aware of the difficulties and might have been expected to do more to try to address them through Trust managers. It is however clear that the Trust and Health Board were aware of the difficulties and trying to resolve them.

Health recommendations.

In relation to the health component of child protection practice in D&G I would therefore highlight the need for:

- **Urgent review of the lead role(s) in relation to child protection cases in D&G, both within and outwith the hospital**. The health board/Trust needs to ensure that expert clinical opinion is consistently available, including not only identification and examination of children that may have been abused physically, sexually, emotionally, (and including neglect of their care), but also effective multi-agency working from the point of referral through case conference to any court process to ensure the child is protected. The current proposal that one of the consultants within the reconfigured service would have 2 designated sessions would seem wholly inadequate for a population of the size and profile of D&G. Adequate arrangements also need to be made to cover these responsibilities when the lead clinician is on leave. Greater involvement of the Community Paediatric team should be considered.
- **The development of systems to provide for both Preliminary (comprehensive) medical assessment** and Joint Paediatric/Forensic examinations and their timely and effective documentation, in keeping with recent Scottish Executive guidance(3). These need to be put in place without delay.
- **The establishment of clear and rapid channels of communication** between hospital staff, general practitioners and health visitors relating to children at risk at times of admission, discharge and follow up to ensure effective sharing of information
- **The training of medical staff**, particularly in clinical evaluation and report writing, in the preparation of and presentation of evidence in Court, and in the legal processes which may be invoked to protect children from further harm.

- **A clinical network for paediatric, forensic and other speciality input, advice and peer support.**
- Arrangements for **the clinical supervision and support of health visitors** to be put in place.

Social Work recommendations

In relation to the social service component of child protection practice in D&G I would identify the need to:

- Ensure that the local social work services procedures compliment and are consistent with the **collaborative approach** endorsed within current Scottish Executive and D&G interagency guidance.
- **Ensure that staff in positions of responsibility have adequate training and experience** in all aspects of the work, to fulfil those roles effectively.
- Ensure that **appropriate supervision** is offered and sought by the team managers in decision making.
- **Provide training particularly in risk assessment, decision making and the legal processes.**
- **Clarify the roles and relationships within the team**, in particular the working relationships between the hospital social workers the geographically based workers and the team manager.
- **Investigate and eradicate the inappropriate use of planning meetings** in place of CPCC.
- **Provide training in handling difficult and hostile parents/carers** ensuring that it does not jeopardise the effective protection of the child.
- **Set up networks of advice and support.**

Interagency recommendations.

In order to promote more effective joint working practices in D&G I would suggest there is a need for the Child Protection Committee to:

- **Ensure that the Child Protection Committee is fully aware of working practices, current statistics (including registrations) and training programmes and briefed on any serious difficulties that are encountered.**
- **Institute a formal stage of initial referral discussion**, ensuring that background information is effectively shared and that **all referrals** are discussed with senior and experienced professionals in social work, health and police and that no agency (and certainly no single individual) can take a unilateral decision not to proceed with a full child protection investigation in the face of serious concerns from another.
- **Review all the decision making processes involved in working together**
- **Review all the guidelines** that are in place to ensure that they are consistent with each other, facilitate good working together and have clear ownership.

- **Put in place interagency training packages for different grades of staff and levels of experience ensuring that the trainers have the necessary skills and experience to offer that training**.
- **Ensure that all staff have access to advice whenever it is required** i.e. including out of hours, and whatever the nature of the problem. This will mean that a network of support must be identified from outwith Dumfries and Galloway particularly during periods of staff leave and in complex cases.
- **Consider the inter-personal aspects of child protection working** and identify strategies to address these.

4.2 National

Although it is clear that there were opportunities to do more to protect Kennedy, what is not clear is whether if this set of circumstances had arisen in another relatively isolated District General Hospital and local Authority area the outcome would have been any different. Whilst I think it almost certain, based on my experience on national working groups and committees and my involvement in the setting up and review of specialist clinical services for child abuse in other areas, that in any of the major teaching centres in Scotland this case would have been referred to, or at least discussed with, a specialist paediatrician working closely with experienced social work, forensic and police colleagues, I suspect that there may be other areas of Scotland where a similar set of circumstances might not lead to an optimum response. In other words **our current services for children who may be subject to abuse and/or neglect are not equitable**. My own experience of reviewing case files from different parts of Scotland, in relation to provision of expert evidence for the defence team in child abuse, would tend to confirm this and also raise questions about the consistency of the response of other agencies including the Children's Hearing system.

Considering the implications of this inquiry for services in other parts of Scotland I would therefore make the following observations:

Health

Child protection is a highly skilled and demanding area of work. It is increasingly viewed as a sub-speciality within paediatrics (particularly community paediatrics) with tertiary centres having specialist teams to which all cases of sexual abuse and all cases of serious and complex abuse or neglect are referred. This has been clearly identified within the Scottish executive guidelines for Health professionals and District General Hospitals need to review their current staffing and facilities and make appropriate arrangements to access expert assessment and advice.

Staff at all levels involved in child protection also need:

- **ready access to advice and guidance from experienced colleagues (including forensic, and sub-speciality),**
- **regular peer review of casework**,
- **personal and professional support**.

- **Opportunities for ongoing training and professional development**

This will be achieved by the setting of **clinical standards** and the **setting up of clinical networks** offering opportunities for effective collaboration and training. This must include standard documentation and time scales for report writing and training in Court skills.

Social work

This case highlights again the need for:

- **meticulous attention to detail in investigating child abuse**
- **effective sharing of information.**
- **The need for regular and meaningful supervision** -which takes priority even at times when the urgency of difficult cases may threaten to displace it recognising that these are also the times when hasty inappropriate judgements may be made.
- **team building and training within social work as well as between agencies** to facilitate meaningful joint working and decision making.

Interagency

Like others before it this inquiry concludes that it is not enough to have in place combined and integrated services and clear agency and interagency guidelines. To be successful child protection services need to establish meaningful and well understood joint working practices and ensure ready access to expert advice when required. This will require different solutions in different areas depending on geography, local expertise etc. It also requires attention to be paid to the **dynamics of team working.** In order to achieve this we need to:

- Institute an audit of child protection processes across Scotland which looks not simply at numbers of referrals, of children on the register and criminal prosecutions, but at the **consistency and quality of practice** from individual agencies and from agencies working together.
- Put in place meaningful **standards of care** within clear processes of referral, investigation, risk assessment and intervention.
- Raise awareness to **inter-personal relationship** aspects in child protection work
- Ensure that **messages from research** reach both those who plan services and those who deliver them on a day to day basis.

One way forward would be the establishment of a 'National Centre for Child Protection' responsible for the collation of information/research and to act as a focal point promoting best practice.

5. COMMENTARY

It is sobering to note that when Kennedy's case is viewed within the context of other child abuse tragedies (4) and with the knowledge of her family situation which has been gathered since her death (but could and should have been gathered prior to it) it bears many of the hallmarks recognised in the literature as characteristic of fatal abuse.

Kennedy was just under three years of age at presentation, the mean age in a review of 35 inquiry reports into child abuse deaths from 1973 to 1989 (4). She was the youngest child of a very needy mother who had been very young when she started her family and demonstrated clear difficulties in her parenting skills and bonding with Kennedy. These problems became more apparent when the new partner joined the family with Kennedy showing clear signs of physical neglect, emotional deprivation and distress with a return of wetting and soiling. Nursery reported clearly the negative feelings towards Kennedy and the frustration that this regression in Kennedy and increased dependency was producing in her mother. Her withdrawal from nursery (in response to their allegations) placed greater demands on the family with the exacerbation of maternal illness whether factitious or real. If the suspicions of Munchausen syndrome, either in relation to the mother's illness or by-proxy in relation to Kennedy, are correct, then an increased risk of a fatal outcome would again be predicted (6). It is also of note that in most of the cases reported in the literature where abuse within the family has led to violent child deaths there has also been considerable neglect and emotional abuse. Frequently the children who died had been subjected to repeated bruising particularly to the head and body and a significant proportion had been previously hospitalised with injuries, as in this case.

Recognising these similarities and therefore potential prompts to identifying the risk to Kennedy emphasises the need for us to learn from research and inquiries and not simply to apportion blame. In addition the agencies need to carefully weigh up the likely scenario around Kennedy in terms of her mother's contribution to her neglect, abuse and death in considering the future safety of her remaining children.

Similarly a review of previous inquiries raises the same issues of **effective communication** in terms not only of mechanical procedures (forms, faxes, E-mails) but relationship issues at a number of levels as I have raised in this report. Confusion about roles leading to inaction, with each worker believing that responsibility lies with someone else was a regular feature in this case. The tendency for professionals who perceived themselves to be at a lower level in the hierarchy to defer to the opinions of those at a higher level in the organisation, even though those professionals frequently had much less direct contact with the family, was another feature, with health professionals particularly thinking that once the referral to social work was made the child protection issues were no longer their responsibility.

The difficulties experienced by professionals in effectively sharing their concerns at case conferences particularly where they conflict with others views or where parents are present are again a common theme and very pertinent to this case. The risks to children when key professionals are absent on leave, and the dangers of expecting workers who have no

statutory responsibility to monitor a high risk situation e.g. the health visitor, have frequently highlighted.
We need to learn the lessons of these tragedies in maintaining our focus on the child and developing working relationships in which we can trust each other to contribute a clear objective assessment within our remit and competence undistorted by the likely reaction of other professionals or parents. Such trusting inter-professional relationships do not just happen because we put people in specific posts (or even in the same room) and by the laying down of rigid guidelines, but develop over time through joint training and working with meaningful and accessible networks of support.

Finally I would like to highlight the need for staff to have rapid access to debriefing and subsequently to counselling or mental health services when a child for whom they have been actively caring dies particularly in such tragic circumstances. This is not always easy due to the concerns about responsibility/blame and employment issues and to the constraints, at least perceived, of any criminal procedures. We must accept that however good our systems and processes we will not be able to predict or prevent all child deaths at the hands of their carers.(7) just as we cannot prevent all deaths from accident or illness. Although that statement will be of no comfort to Kennedy's natural family in their loss, it may reassure some of those in the 'front line' who did their best in this difficult situation.

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