REPORT
of the
CALEB NESS INQUIRY

Executive Summary and Recommendations

Chair: Susan O'Brien QC

Dr. Helen Hammond
Moira McKinnon

October 2003

Commissioned by Edinburgh and the Lothians Child Protection Committee

0 EXECUTIVE SUMMARY

On 18 October 2001, Caleb Alexander Ness was admitted to the Royal Hospital for Sick Children, Edinburgh, and pronounced dead. It was immediately suspected that the baby had been the victim of non-accidental injury, and an autopsy was carried out. There was evidence of very widespread focal fresh haemorrhage in all the compartments of the brain. The findings suggested rapid death following traumatic injury, probably caused by rough shaking of the baby. There was also evidence of 14 definite rib fractures, with three categories of age relating to those fractures. Some were new, probably sustained during the course of the morning of 18 October; some fractures were approximately one week to ten days old; and one fracture was several weeks old. It was concluded that there had been at least three separate episodes of trauma to the chest, probably caused by gripping during shaking. Caleb had been born on 30 July 2001, and was 11 weeks old at the time of his death. He spent the first three weeks of his life in a special care baby unit in hospital.

The baby's mother had been a drug addict for over 20 years, and was taking methadone by prescription throughout her pregnancy. She had a long history of prostitution, and many criminal convictions. Her two children had ended up by being taken into care, after many unsuccessful efforts had been made to end her addiction. News of her pregnancy in 2001 only reached the social work department by chance.

The baby's father, Alexander Ness, went to trial, charged with assault and murder. Eventually, in February 2003, he pled guilty to culpable homicide. It was accepted that he could establish diminished responsibility caused by brain injuries he had sustained some months before the baby was born. He had met the mother, Shirley Malcolm, in the autumn of 2000, soon after being released from prison on licence after serving most of a five year sentence for drug related offences. His earlier criminal history included a conviction for very serious assault of an adult.

A Child Protection Case Conference was held while the baby was still in hospital on 9 August 2001. Caleb was put on the Child Protection Register. Later, he went home with his mother. It was well known that his father would be visiting often, although he was not actually living with the mother. No further decision or formal review of risk took place before the baby died.

The Inquiry has reached the conclusion that this was an avoidable child death. Having reviewed all the evidence, we believe that neither parent should have had unsupervised care of Caleb.

No single individual should be held responsible. We identified fault at almost every level in every agency involved. Many concerned professionals did their best for this family, but too many operated from within a narrow perspective without full appreciation of the wider picture. We are concerned that, two years after Caleb's death, there is still complacency about this blinkered approach to child protection, particularly at a management level.

We are aware that many of our recommendations are not new, and that many have been made before, in earlier reports and reviews. However, we believe that this report

highlights some specific problems in the interface between adult and child services, particularly in the fields of brain injury and substance misuse.

Some of the fundamental factors contributing to this baby's death were:

- Failure to take account of the background information readily available about each of the parents.
    - Shirley's lengthy record of failure to care for her existing two children was dismissed as "historical". Yet there was nothing in the evidence available at the time of Caleb's birth to suggest that there had been a major change to her lifestyle. In particular, she was still seriously dependant on drugs.
    - Alec Ness had suffered a brain injury in January 2001, and a thorough assessment of his disabilities had been made before the baby was born. The social workers concerned (including the criminal justice worker supervising him) did not ask for any medical advice about this, although the information would have been made available to them. Social workers assessing risk to Caleb did not seek information about his criminal background, although they knew that he was on parole.

- Social workers allowed themselves to be easily reassured, largely because the couple was apparently co-operating with them. They failed to undertake a rigorous assessment of risk, and instead took at face value what they were told by Shirley and Alec.

- There was an unspoken assumption that the parents had the right to care for their baby. This dominated events to the extent that Caleb's right to a safe and secure upbringing was never the focus of decision making

- The whole Child Protection Case Conference process was flawed. The report prepared for it was inaccurate in vital respects. In particular, it suggested that the couple was stable, whereas in fact Shirley had made Alec move out a few weeks previously. The gaps in information relating to the two older children in care, Alec's brain injury, the nature and extent of the criminal records of both parents, etc were not identified. The CPCC was not told that Caleb was suffering from neo-natal abstinence syndrome. They did not know that this might make him harder to care for than a normal new born baby. No one attending the CPCC really knew the couple. The Chairperson had never chaired a CPCC before, and had not been trained in how to carry out her role. The Minute taker had never taken Minutes before, and had not been trained in how to carry out that role The people attending the CPCC appear to have had too little knowledge of the roles expected of them. No one was clear about the exact decisions which could and should have been taken at the meeting, including the need to refer such a case to the Reporter. Although the CPCC correctly decided to place Caleb on the Child Protection Register, no detailed Child Protection plan was agreed, and he was therefore left at risk.

- The Minutes of the CPCC were not distributed to the relevant professionals, contributing to a lack of effective monitoring after Caleb left hospital. This was only one of several significant problems we found in the recording and sharing of accurate documentation relating to a baby known to be at risk.

- The social worker and health visitor who were supposed to visit Caleb did so, but not often enough in the circumstances, even allowing for a gap between what was known about his home environment and what was the reality. What monitoring they did do was not jointly planned, or effectively co-ordinated. The Health Visitor did identify increasing levels of risk to Caleb, and notified the case co-ordinator appropriately, but he had formed the impression that Shirley would cope. He did not recognise the need for further assessment of risk after the CPCC. The present system relies too much on the judgment of one individual case co-ordinator.

- The diagnosis of post-natal depression in Shirley, an increase in her methadone prescription, greater confusion and depression in Alec, - all should have been seen as giving rise to escalating concern for Caleb in early October 2001. In fact, because the individual agencies were not working together effectively, the information was collated in a piecemeal fashion, and no single person knew all the relevant facts. No formal decision making process took place at that time, and it should have done.

- We identified the lack of proactive senior social work involvement in the assessment of risk, in the re-assessment of risk, in decision making, and in ongoing supervision, as being a fundamental reason for that agency's failure to protect Caleb.

- There were alarming variations in agency managers' expectations of the appropriate level of monitoring for a baby like Caleb. At every level, in several agencies, the phrase "high level of monitoring" had different meanings.

- There was a tendency among professionals in all agencies to make assumptions about the knowledge, training and actions of others. The doctors assumed that the social workers knew things which in fact they did not. Some professionals failed to acknowledge their own responsibilities for identifying and responding to child protection concerns. This was particularly evident in the gulf we discovered between Children and Families team social workers and the separately administered Criminal Justice social workers. We found that there was a complete failure by Criminal Justice workers and management to recognise that they did have some responsibility for child protection. Similarly, we saw an incomplete understanding of their role in child protection in the actions of addiction professionals and brain injury specialists, who are accustomed to working with adult patients. The police were handicapped by the paucity of information sent to them by the social work department, and did the best they could do in Caleb's case, but we discovered that they were not routinely passing on as much information as the social workers expected.

- Issues of confidentiality were a concern to some of the professionals we interviewed, but did not have any direct bearing on what happened to Caleb. There were examples of people failing to seek information partly because they expected that it might not be forthcoming, such as the criminal justice social worker who failed to ask a doctor about Ness: conversely, the addiction specialist who knew that Shirley was under stress did not see it as his duty to pass that

information back to the case co-ordinator. No one monitoring the pregnancy informed the social work department that a baby was on the way. Generally, the lack of knowledge about the relevant guidance on sharing confidential information in a child protection context was a matter of concern

- Almost all of the professional witnesses identified child protection training as a major requirement before services could be improved. Many expressed the view that it will have to be mandatory at all levels.

- The Inquiry identified an absence of clear accountability for child protection within Health agencies, to the extent that the agencies could not even easily identify an appropriate senior management witness to give evidence. At first sight, responsibility had apparently been delegated to senior practitioners in lead clinician or advisory roles, but for their part, those advisors considered that they could only provide advice and training. They knew that much more needed to be done. True management and budget responsibility tended to rest at a higher level with people who have no training at all in child protection. This is also an issue at high levels within other agencies. We were particularly concerned about this.

- Some evidence suggested that this was not an isolated case.

We were encouraged, however, by the willingness of witnesses to attend this Inquiry, and by their commitment to child protection. We discovered that some practical changes have already taken place, but we could not tell whether they had been implemented throughout the area on a consistent basis. We were grateful for the many positive suggestions for improvements we might consider, and a summary of the Inquiry's Recommendations appears at the end of the Report.

1 SUMMARY OF RECOMMENDATIONS

	Section	Recommendation
1)	3.4.1	**RECOMMEND that the CPCC minute format is changed, so that the Chairperson has an opportunity and obligation to sign the Minutes.**
2)	3.6.2	**RECOMMEND that an explicit discussion and decision as to whether or not the child should be discharged to the care of the parent should always be part of a CPCC for a newborn baby**
3)	4.2.9	**RECOMMEND that a Joint Working Party prepares a Joint Protocol to inform the treatment and care of babies born with neonatal abstinence syndrome**
4)	4.2.9	**RECOMMEND automatic referral to the Social Work Department of any baby born with neonatal abstinence syndrome, who has not been identified pre-birth**
5)	4.3.3	**RECOMMENDATION that the Trust organises and funds mandatory child protection training, as identified by their own specialist**
6)	4.4.6	**RECOMMEND that the Trust carefully reviews its record keeping systems to facilitate effective sharing of information**
7)	4.4.8	**RECOMMEND that Lothian Primary Care Trust urgently allocates resources and skilled staff to institute mandatory child protection training for staff at all levels, which must include advice on the extent to which a patient's right to medical confidentiality can be breached when a child is at risk**
8)	4.5.2	**RECOMMEND that the pro forma invitation issued by Social Work Departments throughout the City should be reviewed, in consultation with the Police, and a new pro forma drawn up, which offers the Police far more information**
9)	4.5.20	**RECOMMEND that the Police review the detail of their approach to physical and sexual abuse in collaboration with Child Protection specialists from outside the Police. Thereafter, we recommend that they re-examine their internal procedures for allocating cases**
10)	4.5.21	**RECOMMEND that a clear understanding is reached between the Police and the Social Workers on information sharing prior to the CPCC**
11)	5.7.6	**RECOMMEND that the Social Work Department refrains from interviewing witnesses where an inquiry has been set up**

12) 8.7 **RECOMMEND that the Housing Department of the City of Edinburgh reviews what happened here, with a view to streamlining and supporting applications by people suffering from brain injury**

13) 8.8 **RECOMMEND that Lothian Primary Care Trust facilitates the registration with GPs of brain injury patients, with a view to providing them with appropriate care outside the hospital**

14) 9.1.4 **RECOMMEND that the section of the Child Protection Guidelines is amended to reflect the expectation that health care professionals will notify the social work department if they anticipate there may be risk after birth for a child still in utero, even if it means breaching the duty of confidentiality owed to either mother or father**

15) 9.1.6 **RECOMMEND that a file entry is made when information is shared in this way, and in particular when liaison workers pass that information out beyond the hospital**

16) 9.1.7 **RECOMMEND that the LUH Trust reviews the accuracy of its record keeping for at risk children**

17) 9.1.10 **RECOMMEND that serious dialogue is undertaken to clarify the role of the Trusts' Child Protection Services within an interagency context**

18) 9.1.12 **RECOMMEND that Lothian Health ensures that its various Trusts fund the training requirements identified by their own senior staff with management responsibility for Child Protection**

19) 9.1.15 **RECOMMEND that the best means of triggering early reviews or immediate action in response to health visitors' concerns be investigated, and improved upon, as a matter of urgency**

20) 9.1.17 **RECOMMEND that steps are taken to clarify when medical duties of confidentiality towards a patient who is caring for a child can be waived**

21) 9.1.24 **RECOMMEND that Children and Families and Criminal Justice social work services review their joint working practices in this area as a matter of urgency**

22) 9.2.2 **RECOMMEND that a checklist of invitees for CPCCs is compiled as an aid for social workers in the future**

23) 9.2.6 **RECOMMEND that all agencies make it a priority to collaborate and put in place effective risk assessment processes to underpin decision making**

24) 9.2.7 **RECOMMEND that the use of Senior Practitioners as Chairpersons of Case Conferences is discontinued**

25) 9.2.8 **RECOMMEND that formal training in how to chair a CPCC is introduced for all new Chairpersons**

26) 9.2.9 **RECOMMEND that the CDPS provides information for the use of CPCCs about the inferences which can be drawn from the factual information they are providing**

27) 9.2.10 **RECOMMEND that Social Workers involved with CPCCs in Lothian are encouraged to refer to the Reporter, where there is a history of previous children who have been taken into care, unless the circumstances are exceptional.**

28**)** 9.2.10 **RECOMMEND that CPCC Chairs, in discussion with the Reporter, agree appropriate referral criteria**

29) 9.3.1 **RECOMMEND that resources are allocated for the employment and training of administrative staff to take and type up Minutes relating to CPCCs**

30) 9.3.2 **RECOMMEND that the pro forma Minutes are changed slightly, to include a section for signature by the Chair of the relevant CPCC**

31) 9.3.6 **RECOMMEND that the supervising Senior Social Worker should attend Child Protection Case Conferences, along with the case worker from the Children and Families Team**

32) 9.3.15 **RECOMMEND that consideration should be given to this model of a "core group", as a means of developing and implementing the Child Protection plan**

33) 9.3.16 **RECOMMEND that senior managers with responsibility for child protection practice have appropriate training to discharge that responsibility, in every agency**

34) 9.3.17 **RECOMMEND that the Chief Executives and Medical Directors give urgent consideration to lines of accountability**

35) 9.3.18 **RECOMMEND that an independent audit of Child Protection cases is carried out**

Recommedations grouped by agency

Some recommendations appear more than once.

More than one agency: 1, 2, 3, 4, 8, 10, 14, 17, 18, 19, 20, 23, 30, 32, 33, 35.

Mostly Social Work: 21, 22, 24, 25, 27, 28, 29, 31.
Mostly Lothian Primary Care NHS Trust: 7, 13, 18, 26, 34.
Mostly Lothian University Hospitals NHS Trust: 5, 6, 15, 16, 18, 34.
Mostly Police: 8, 9, 10.
Housing: 12.