V A L E O F G L A M O R G A N
B R O M O R G A N N W G

EXECUTIVE SUMMARY PREPARED FOR THE VALE OF GLAMORGAN AREA CHILD PROTECTION COMMITTEE

Serious Case Review
Child 1 female b. 21.6.00
Child2 male b.11.9.02

JULY 2004

Forward by Chair of ACPC

The Vale of Glamorgan Area Child Protection Committee commissioned this Serious Case Review when it was reported that a child, who had suffered serious injuries, had not been appropriately protected by current inter-agency policies and safeguards.

The Area Child Protection Committee was determined to understand why the injuries had occurred in order above all, to prevent another child or children from suffering such injuries. As part of protecting other children in future, the Committee was concerned, to ascertain whether there were any shortcomings in policy or procedure that had contributed to the injuries and identify what remedial action it should take, if any.

Area Child Protection Committees are required by Welsh Assembly Government Guidance (as set out in 'Working Together – A guide to inter-agency working to safeguard and promote the welfare of children' 2000) to conduct this kind of review whenever "….a child has sustained a potentially life-threatening injury through abuse or neglect,…..or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard children."
('Working Together Section 8.6). This was one such case.

The Overview Report, which was written by Ruth Forrester, Independent Consultant, was considered in detail at the March meeting of the Vale of Glamorgan Area Child Protection Committee and was accepted in its final form at its subsequent meeting in May.

The Committee welcomes the report and commends the quality of the work undertaken by agencies and by the overview author, to produce the report.

At the time that the agencies became aware of their situation in December 2002, the children were aged 14 weeks and 2 years old. The children did not die. Both children are well and are making good progress.

Although the family were not well known to the Social Services Department, there were some early indicators of child abuse and neglect. These were not recognised by some of the professionals in touch with the children.

The Vale of Glamorgan Area Child Protection Committee will address the Recommendation energetically to ensure that systems, staff attitudes and resources provide a safer environment for children in need of protection. An Action Plan will be produced which will meet each of the Recommendations.

There is a need for all practitioners in child protection to read the Executive Summary and to consider how the report is relevant to their work.

Tony Young
Head of Children and Family Services
Chairman of the Area Child Protection Committee

1. Why was there a Serious Case Review?

- After Christmas 2002, an infant child then aged 14 weeks was admitted to a District General Hospital with a fracture to his leg. Subsequent medical investigation showed that he had multiple fractures, including fractures to his ribs and bruising. These fractures were several weeks old.
- He had had two previous admissions to the District General Hospital.
- His sister, then aged 2 years had also had an admission to the District General Hospital.
- The Area Child Protection Committee (ACPC) decided to undertake a Serious Case Review under Part 8 of the revised edition of *Working Together to Safeguard Children*, which was issued by The National Assembly for Wales in September 2000. The ACPC considered that the child concerned had:

  sustained potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect and the case gives rise to concerns about the way local professionals and services work together to safeguard children.
- The child survived the injuries and has made very good progress and appears to have sustained no lasting damage from them. This is an opportunity to examine practice and make recommendations for changes, without the tragedy of a child who did not survive.

2. How was the Review Completed?

- A Serious Cases Review Panel was convened and it was agreed to undertake full management reviews of the involvement of Health, Police and both the Social Services Departments involved, with other agencies such as Housing, Probation, Education and NSPCC to be asked to contribute as appropriate.
- Four full Management Reviews were completed by:
  - The Social Services Department
  - The Police,
  - The National Public Health Service, Child Protection Service for Wales
  - The Day Nursery involved with one of the children
- Each of the Management Reviews contained a series of recommendations and the agencies concerned have completed Action Plans to address the recommendations.
- The ACPC commissioned an independent consultant to complete the Overview Report. Staff from a range of agencies have been interviewed and case records have been accessed where appropriate. Staff from all agencies co-operated fully with the Serious Case Review

- The Overview Report has been accepted by the ACPC and an Action Plan to address the recommendations is being completed.

3. What Happened to the Children?

- This is **not** a situation where the family was well known to the Social Services Department. The involvement with the parents and the children was largely through primary health care services and District General Hospitals.
- The family are White Welsh in ethnic origin and have lived in the area all their lives.
- The mother is part qualified as a nursery nurse. Child 1, a girl was born in 2000, the result of her first serious relationship. The mother was then aged 20. In 2001, she formed another relationship with the father of Child 2. Child 2 was born in September 2002.
- Child 1 made good progress but there was some concern by the Health Visitor about stresses within the home and Child 1 was placed in a Day Nursery. Child 1 was admitted to the District General Hospital in March 2002. She was then only 1 year old and had bruising but the explanation of a domestic accident was accepted.
- There were stresses in the relationship between the mother and her new partner. The Police were called to the house in June 2002, following a complaint of domestic violence. Her partner was arrested following an assault on the police officers attending the incident and he was convicted by the court and fined.
- The information about the domestic violence incident was passed by the Social Services Department to the Health Visitor in September 2002, just before Child 2's birth.
- Child 2, a boy was born in September 2002. At birth he was a normal weight and made good progress at first but when he was about 4 weeks old, he showed signs of problems. His weight started to fall. There were no obvious reasons for this weight loss. By the time he was just over two months old, his weight had fallen to the ninth centile.
- Because of concerns about his weight loss, Child 2 was admitted to the District General Hospital at the end of November 2002. He was found to have an ulcer on the soft palate of his mouth. He was discharged and returned to hospital in early December 2002 for an X Ray. This was done but it did not show abnormalities.
- His General Practitioner saw him again in early December. His mother was still concerned that he was not feeding well. Child 2 was readmitted to the District General Hospital again but he was discharged the next day.
- Child 2 was admitted again to the District General Hospital after Christmas 2002, this time in an emergency. Child 2 had a broken leg. The hospital staff suspected that this injury was not accidental and decided to undertake more investigations. There was concern that there might be a head injury. Further investigations showed that there was also a fracture of

the right leg, and multiple fractures to the ribs. When the X ray taken in early December 2002 was reviewed, it was found that the fractures to the ribs were present. There was no head injury.

- The Police and the Social Services Department undertook a joint investigation as soon as Child 2 was admitted to hospital. Child 2 remained in hospital. Child 1 was placed with a relative. The Social Services Department began care proceedings.
- The mother and her partner were interviewed and charged with grievous bodily harm.
- The Crown Prosecution Service decided not to continue with criminal proceedings. Care proceedings are continuing. Both children are placed within the extended family. They are making very good progress.

4. What are the Key Issues Arising out of the Review and the Lessons to be Learned ?

There were a number of opportunities when the actions of, or lack of action from, professionals working with these children and their family affected the eventual outcomes for them

These include:

- Delay by the Social Services Department in passing information about the domestic violence incident to the Health Visitor
- Early recognition of the seriousness of the failure to thrive, shown through his failure to gain weight of Child 2 by Health Visitors, poor recording of the weight loss by Health Visitors and the Community Midwife and poor communication between the General Practitioner and the Health Visitor
- An assumption by the District General Hospital that the failure to thrive of Child 2 was caused by organic factors despite the evidence that his mother was seriously stressed
- Failure to identify rib fractures from the first X ray
- Failure by the District General Hospital to link the admission of Child 1 with the admissions of Child 2, despite the fact that this was the same District General Hospital
- Failure by the District General Hospital to provide the Social Services Department and the Police with a medical report for over two weeks after admission. This delayed the care proceedings to protect the children and placed Child 1 at risk
- Failure to hold a Child Protection Conference. The Social Services Department dealt with the situation through Strategy Meetings
- Placement of Child 1 with a relative who had not been assessed.

There were areas of good practice from a variety of agencies and professionals who had and these must be recognised.

- Health Visitor1 identified Child 1 and Mother's needs at an early stage and referred Child1 to the Day Nursery. A structure existed for assisted fees to be paid.
- The Day Nursery gave Child 1 very good support during a difficult period and produced a vivid picture of Child 1 and helpful comments about the parenting capacity of Mother and Relative1. It is possible that the support and monitoring by the Day Nursery prevented further physical abuse to Child 1.
- The District General Hospital checked the Child Protection Register for Child 1's admission to hospital.
- The Social Services Department have SWIFT, a client database and all contacts with the children including multi agency contacts.The Social Services Department have clear procedures for the response to referrals.The Social Services Department have good management systems and were able to provide evidence of staffing levels immediately.
- The Police responded immediately to the domestic violence referral.
- Mother received a good standard of antenatal care, and there was intensive, committed support to Mother and Child 2 after his birth by Health Visitors, the Community Midwife and the General Practitioner. There seemed to be good relationships between Mother and primary health care staff.
- The General Practitioners referred Child 1 to the District General Hospital appropriately.
- The District General Hospital undertook full investigations of Child 2, once child abuse was suspected. Severe brain injuries were excluded.
- Hospital recording was of a high standard. Records were very full and complete and each entry was signed and dated.
- Parents received good support from the District General Hospital in difficult circumstances.
- After an initial delay, the Social Services Department responded positively to the referral from the District General Hospital . The matter was referred to the Police and a Strategy Meeting was organised quickly. Legal support from the Local Authority was provided quickly. A social worker was allocated. There was excellent communication between the Social Services Department and the Police and an immediate response to a perceived danger to Child 1.
- The Police and the Social Services Department made positive and persistent efforts to secure a medical report.
- Both children were placed within the extended family.
- All those staff I have had contact with, either through the preparation of Management Reviews or through interview and discussion have a genuine wish to improve services and to reflect on their professional practice. There is no sense of defensiveness.

Lessons which need to be learned

Communication and information sharing

- Most public enquiries on the death or serious injury of children point to failures in communication. Whilst there were a number of examples of good communication, there were significant delays and failure to share information between agencies and within agencies.
- The most serious example is the delay in the District General Hospital providing a medical report to the Social Services Department. This not only had potentially serious consequences for the children but also has damaged professional networks within the area. The reasons for this delay are still unclear.

Understanding of the symptoms of physical child abuse

- Child 2 showed distress from the beginning of his life. His failure to gain weight was very clear, but it was assumed that it had an organic cause. It was not linked with Child 1's admission to hospital with suspicious bruising and the domestic violence referral although both were known to the Health Visitor.
- The first X ray showed the fractures to Child 2 but they were not identified until the X ray was reviewed by a paediatric radiologist. Fractures in infants are difficult to identify. Nevertheless if they had been identified, Child 2 would have been saved from further physical abuse, and action could have been taken sooner to protect Child 1.

Listening to the voice of the child

- Child 2 was a small baby and it could be argued that he could not express his wishes and feelings. He was trying to communicate his distress in a number of ways but these were misinterpreted. As soon as he was protected, he began to gain weight and feed well.

Staffing, access to family support services and work with men

- It is not clear whether or not there were capacity problems for the Health Visitors. The staffing situation for the Social Services Department both at the time of the domestic violence referral (in June 2002) and the admission of Child 2 to the District General Hospital (in December 2002) was very difficult as a consequence of staff vacancies. There were large gaps in both Social Workers and Senior Practitioners and therefore insufficient numbers of staff to receive and understand referrals and to undertake assessments.

- Although there are some preventative services in the Vale of Glamorgan, such as the Day Nursery Child 1 attended, there are limited resources to support families. There needs to be an agreed multi agency approach to supporting families expressed through a Family Support Strategy.
- There are only limited resources to work with male perpetrators of domestic violence. Most victims of domestic violence return to perpetrators.

Recording and report writing

- There were significant weaknesses in recording by both the Social Services Department and Health Visitors.
- In the Social Services Department, important management decisions were not always recorded
- For Health Visitors, recording took place on a number of systems including the PCHR (parent held record), the electronic system and Epex.
- Baseline health data (height, weight and head circumferance) was not entered on the centile chart in the child's record
- The District General Hospital failed to complete a report on Child 2 in a timely way and there are no discharge summaries on Child 2.

Supervision, monitoring and clinical governance

- Although there were clear procedures in the Social Services Department, these were not always followed. There was the use of unqualified staff to receive referrals, but because of staff vacancies, their work was not always monitored and supported.
- Staff capacity within the Social Services Department appeared to be insufficient to meet the peaks of demand.
- Audits of referrals, as recommended in the Victoria Climbie Report were not embedded in practice.
- The Regulations relating to the assessment of relatives caring for Looked After Children were not followed.
- There did not appear to be a system for monitoring the work of Health Visitors. Health Visitors did not maintain a database of children in need.

Training

- There was a wide variation in the adherence by practitioners to the Child Protection Procedures with many failures in communication between practitioners.

- Examples include failures in communication about the domestic violence referral; the failure to link Child 1 and Child 2 in terms of their admission to hospital; delay in supplying reports by the District General Hospital ; communication via family members rather than through professionals; the lack of a Child Protection Conference and the failure to assess a relative before placing a child with her.

5. Recommendations

Introductory Comments

The Overview Report makes recommendations for the Vale of Glamorgan Area Child Protection Committee and the agencies who are members of the Area Child Protection Committee. The Management Reviews have made specific recommendations for each agency and as far as possible, these recommendations are related to the main Area Child Protection Committee recommendations.

Recommendation 1

The Social Services Department in partnership with the Area Child Protection Committee and voluntary organisations should develop a Family Support Strategy for children and families in need for the Vale of Glamorgan. This Family Support Strategy should encompass services for families affected by domestic violence, and work with male perpetrators of domestic violence.

Recommendation 2

The Area Child Protection Committee review referral pathways for perpetrators of domestic violence and ensure that they are referred to services.

Associated Recommendations

South Wales Police

Domestic Abuse coordinators monitor FSU9 Domestic Abuse forms to ensure child protection issues are addressed.

Social Services Department

That Children's Services, in consultation with key stakeholders present its policy review on responses to the Area Child Protection Committee in February 2004.

Recommendation 3

The staffing levels in Health and the Social Services Department should be reviewed. In particular, the Social Services Department should review staffing levels of the First Response Team and the Bro Morgannwg NHS Trust to consider staffing levels in the District General Hospital, taking into account staff absence and difficulties in recruitment.

Associated Recommendations

Social Services Department

Consideration is given to the allocation of possible additional resources following the submission of Children's Policy Review on Domestic Violence to the Area Child Protection Committee. This could for example be on the basis of a one year multi-agency pilot to meet the growing demands of domestic violence incidents.

Bro Morgannwg NHS Trust Bridgend LHB in conjunction with Bro Morgannwg NHS Trust

Review the hospital Health Visiting Liaison process to ensure sufficient resources are available to facilitate effective communication between hospital and community and vice versa in line with the 'Service Specification for Child Protection, Children Looked After and Related Services for All Health Organisations'.

Recommendation 4

The ACPC must ensure that all professionals, who are in contact with children and their families, have sufficient knowledge to recognise possible abuse and the associated risk factors. Particular attention should be given to:

physical abuse,

failure to thrive,

association with alcohol and drugs

domestic violence.

Associated Recommendations

Bro Morgannwg NHS Trust

Reviews Radiology Services for children within the Bro Morgannwg NHS Trust

Bro Morgannwg NHS Trust

Ensures that there is a review of paediatric X rays by 2 radiologists.

Bro Morgannwg NHS Trust

Reinforce to all community health nurses and Health Visitors that where an infant's weight crosses two centiles, they must seek the advice of General Practitioners or Paediatricians.

Bro Morgannwg NHS Trust

Give consideration to developing a protocol on respect of babies who fail to thrive.

Social Services Department

The Vale of Glamorgan Area Child Protection Committee Sub Committee for Policy and Procedure include in its programme a Policy on Neglect

Bro Morgannwg NHS Trust

Must always ensure that the PCHR centile chart is always completed when a child is weighed or measured. When failure to thrive is identified by the crossing of two centiles, a separate centile chart must be raised to form part of the Health Visitor core documentation and consideration to identifying the child as a child in need via utilisation of the child health needs scale assessment process due to be implemented across the Trust. This will then also require the raising of the 'Child Health Additional Recored'. A base measurement of height, weight and head circumference must be completed at the Health Visitor's first infant assessment (ie the birth visit) and documented both in the PHCR and the Health Visitor's own record.

South Wales Police

Domestic abuse coordinators monitor FSU9 Domestic Abuse forms to ensure child protection issues are addressed.

Recommendation 5

The ACPC must ensure access to the child protection procedures to all appropriate agencies, provide training and regularly audit:

the availability of the procedures,

access to the procedures in terms of format and language,

training needs.

Associated Recommendations

South Wales Police The Area Child Protection Committee should ensure multi-agency thresholds and indicators to identify child protection issues are consistently used across agencies.

South Wales Police The Area Child Protection Committee should ensure prompt referral to partners in accordance with the Area Child Protection Committee All Wales Child Protection Procedures to enable a co-ordinated investigation to take place

South Wales Police Training for Child Protection Officers must equip them with the confidence to question the views of professionals in other agencies, including doctors, no matter how eminent those professionals appear to be (also Recommendation 100 – Climbie Report)

Recommendation 6

The ACPC should review systems to audit compliance with procedures, which should include:

individual agency auditing,

auditing of the multi-agency aspects of child protection.

Associated Recommendations

South Wales Police

The Area Child Protection Committee should ensure multi-agency thresholds and indicators to identify child protection issues are consistently used across agencies.

South Wales Police

The Area Child Protection Committee should ensure prompt referral to partners in accordance with the Area Child Protection Committee All Wales Child Protection Procedures to enable a co-ordinated investigation to take place.

Bro Morgannwg NHS Trust

Should reinforce to all community health nurses and Health Visitors that where an infant's weight crosses two centiles, they must seek the advice of General Practitioners or Paediatricians.

Bro Morgannwg NHS Trust

Should give consideration to developing a protocol on respect of babies who fail to thrive.

South Wales Police

Domestic abuse coordinators monitor FSU9 Domestic Abuse forms to ensure child protection issues are addressed.

Recommendation 7

The ACPC should review the protocols for the sharing of information within and between agencies. Staff should be reminded of their responsibilities. Guidance should be developed which encourages them to exercise professional discretion and challenge other professionals. This must be supported through adequate supervision processes and access to specialist advice.

Associated Recommendations

South Wales Police

All professionals should ensure discharge planning is considered at early strategy meetings and any deviation from the plan is shared with partners prior to discharge

South Wales Police

Submission of written reports should be timely so as not to adversely affect subsequent investigations.

South Wales Police

The Area Child Protection Committee should agree a protocol inn relation to access to hospital files when a Section 47 or joint criminal investigation takes place.

Bridgend LHB in conjunction with Bro Morgannwg NHS Trust

Review the hospital Health Visiting Liaison process to ensure sufficient resources are available to facilitate effective communication between hospital and community and vice versa in line with the 'Service Specification for Child Protection, Children Looked After and Related Services for All Health Organisations'

Bro Morgannwg NHS Trust/ Vale of Glamorgan Local Health Board

A review of policy regarding discharge summaries and correspondence between Hospital and Primary Care Team

Vale of Glamorgan Local Health Board

General Practitioners also need to review their policy regarding information sharing between the Primary Care Team.

Bro Morgannwg NHS Trust

It is standard policy that if a child is admitted to hospital with a diagnosis of possible non accidential injury, a report would be written within days of admission, and copies sent to both the Police and Social Services.

Bro Morgannwg NHS Trust.

It is suggested that Police statement paper is available in the hospital, and there is an expectation that Medical Officers write their own statements. It is essential that all relevant information is shared.

Social Services Department

That the Vale of Glamorgan Area Child Protection Sub Committee for Policy and Procedure revise as necessary the Vale of Glamorgan Multi – agency Assessment Framework Protocol and present it to the Area Child Protection Committee in April 2004. This work will need to be undertaken in partnership with the City and County of Cardiff Area Child Protection Committee as Cardiff has adopted the Vale of Glamorgan's Protocol to ensure consistency of identification, reporting and referral for Health professionals.

Social Services Department

The Vale of Glamorgan Area Child Protection Committee Sub Committee for training raise multi-agency awareness of the Assessment Framework Protocol, giving particular regard to the importance of relevant Health professionals in due processes.

Recommendation 8

The ACPC should use the *Assessment Framework* to ensure that staff develop skills and competencies in assessment and care planning for children in need or at risk of significant harm.

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Recommendation 9

The ACPC should review the recording systems of each of its member agencies in relation to child protection and develop standards to ensure that each agency records the information, which is necessary to safeguard and promote the welfare of vulnerable children.

Recommendation 10

The ACPC should ensure that the findings of this serious case review are disseminated to all interested parties.

Potential National Issues

A national review of case recording and record keeping in relation to children in need.

A review of all cases where X rays have been misinterpreted with consideration to technological solutions to the difficulty of reading X rays on babies.