EXECUTIVE SUMMARY

SERIOUS CASE REVIEW
02/08

Commissioned by the
Vale of Glamorgan Safeguarding Children Board

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1 Introduction

This Serious Case Review (SCR) examines the involvement of agencies with 'child 1' and his family between 1st March 2005 and 20th January 2006. 'child 1' is born on the 18th December 2005.

He was admitted to hospital at the end of December 2005 for failure to thrive having lost 8% of his birth weight. He was discharged at the beginning of January 2006 but readmitted ten days later. Four days after his admission to hospital a staff nurse discovered his father with his hands around 'child 1's neck. The nurse removed 'child 1' from father's care and a referral was made to social services. A strategy meeting involving the police, social workers and health service staff agreed further inquiries and investigations should be made. Isotope bone scans revealed hot spots indicative of probable acute fractures. 'child 1' was removed from his parents care and placed with foster carers.

The Case Review Panel overseeing this review comprised experienced professional representatives from the following services National Society for the Prevention of Cruelty to Children (NSPCC), National Public Health Service for Wales (NPHSW), Vale of Glamorgan Council.

An independent person was appointed to prepare the overview report. He has more than thirty years experience of social care the majority of which has been concerned with services for children and families. He has a professional social work qualification and MA and is registered with the General Social Care Council. He regularly undertakes agency reviews and provides overview reports to Local Safeguarding Children Board's (LSCBs) in England and Wales.

The aim and value of a serious case review is to reflect on events analytically to identify whether arrangements to protect children can be improved further.

The Review achieved this by;

1. Establishing the facts of the case in relation to each individual agency involved.

2. Considering the events, the decisions made and actions taken or not taken.

3. Establishing the lessons to be learnt from the case to further improve the way in which local professionals and organisations work together to safeguard and promote the welfare of children.

4. Identifying clearly the lessons for each agency, how they will be acted upon and what is expected to change as a result.

5. Establishing clear action plans for individual agency to implement.

6. Provided a multi agency overview report in accordance with national guidance to the Local Safeguarding Children Board (LSCB).

7. Developed a clear multi agency action plan from the overview report.

8. Provided this executive summary for publication.

2 The Individual Agency Reviews.

2.1 Summary

The individual agency reviews confirmed that professionals responded to concerns about and were conscientious in their support and oversight of 'child 1' during and following his discharge from hospital.

Health staff at the hospital made an appropriate referral to social services. Both the police and social services ensured that 'child 1' was provided with appropriate care and safe supervision.

The review acknowledges that some information could have been shared more clearly although this did not have any detrimental effect on P's safety. The review also recognises that although some areas have the benefit of good quality services such as Flying Start, in others it can be difficult to provide practical support to young parents. The review also highlights how identifying signs of domestic abuse is an important function and responsibility of all services.

The detailed examination during the review of practice and decision-making highlighted improvements that will further future enhance safeguarding arrangements for children in the Vale of Glamorgan.

2.2 Issues highlighted as a result of the review

The agency reviews identify themes that have implications for policy development and staff training that applies to all services working with children. These include:

- Information sharing/communication;
- Recording information;
- Access to management advice and support outside core office hours;
- Reporting concerns about children outside core office hours;
- Knowledge and understanding about indicators of possible domestic violence;

- The importance of medical and forensic procedures in identifying and managing risk to children.

Issues highlighted for health professionals in particular include:

- Ensuring all professionals are confident to act directly and immediately when they have concerns about the safety of a child;
- The importance of vigilance when young children display signs of faltering growth and development, especially when organic explanation is not ruled out, is improbable or unlikely;
- The value of scans and x-rays that can show injuries that are not visible from a physical examination;
- The importance of practitioners being aware of indicators of possible domestic abuse and ensuring that other professionals involved with the family are made aware;
- The valuable contribution that can be made by specialist lead professionals who have particular knowledge and experience in relation to the protection of children;
- The importance of staff having clear arrangements for managing violent or unpredictable behaviour;

Issues highlighted for the police include;

- The importance of having specialist officers from the Child Abuse Investigation Unit (CAIU) available and able to respond out of hours;
- The need for clarity regarding which area takes the lead in any inquiries or investigations in the event of concerns arising when a child is living temporally in another area away from home;
- Recognising that incidents or allegations concerning the safety of a child require investigating irrespective of whether the child has been moved to a place of safety.

Issues highlighted for social services include;

- Allocation and completion of assessments need to comply with national standards;
- The importance of managerial oversight and scrutiny of practice and case recording;
- Ensuring that recording in general and assessments in particular, are completed promptly and inform clear planning of arrangements and services.

3 Conclusions and recommendations

3.1.1 Good practice

The case review panel identified good practice in this case. Particular examples include;

- Prompt action by health staff when they become concerned about the safety of 'child 1'
- The contact and oversight provided to 'child 1' following his discharge from hospital and the action taken to readmit him when faltering growth is a concern
- The consistency of professionals attending and contributing to the strategy meetings to ensure clear communication.

3.1.2 Sharing information

This review highlights that for children living outside areas targeted for support through services such as Flying Start there are limited opportunities to provide practical support and help to vulnerable families unless or until their circumstances merit formal intervention as children in need and/or requiring protection.

Recommendation one

The LSCB should review current information sharing and referral arrangements for vulnerable children to ensure that appropriate support is provided prior to any escalation to more formal intervention, for example a referral to social care services. The review should also examine whether an appropriate range of services are available. In undertaking this review, the LSCB should seek information regarding operation of the common assessment framework in the five pilot areas in Wales.

Every local authority in Wales will be required to produce a Children and Young Person's Plan from 2008. The Children and Young People Partnership (CYPP) will cover all services provided by the local authority and its relevant partners that impact on children and young people up to the age of 25, including maternity services. Each CYPP will set out the improvements to be made in the well-being of children and young people in the authority's area with reference to the Assembly Government's seven core aims.

Recommendation two

The LSCB should review arrangements for contributing to strategic service planning for vulnerable children and families, and ensure that the preparation, consultation and implementation of the Children and Young People's Plan[1] improves co-ordination and access to services for vulnerable children across the borough.

3.1.3 Responding to referrals

[1] The Children and Young People's Plan (Wales) Regulations 2007

Although the response to the referral on the 16th January was prompt the management of a previous self-referral by P's mother was delayed.

Recommendation three

Social services should report to the LSCB what information is currently provided regarding the operation of referral and assessment services for children in the Vale of Glamorgan. This should identify what data is routinely collected, the measures for managing performance and compliance, and information about resources such as staffing.

3.1.4 Accuracy of information recorded at strategy meetings

The case review panel examined the minutes of the two strategy meetings. Some of the decisions recorded in the minutes are at variance to those noted in some of the agency reviews. This includes agency understanding about the legal status of the children. The panel are satisfied that these deficits did not compromise the safeguarding of 'child 1' but it nonetheless raised some concerns about the quality of information sharing and recording.

Recommendation four

The LSCB should review the adequacy of current audit arrangements in relation to monitoring the operation of core safeguarding processes. The review should establish whether sufficient quality and quantity of information is routinely gathered to inform judgements about the adequacy and quality of practice and performance. Particular regard should be given to the quality and accuracy of key records that include strategy meetings, section 47 enquiries, core groups and child protection conferences.

There is reference in the minutes of a meeting to an adult who is not a member of the immediate family having 'schedule 1 offences'. The offences referred to in the minutes of the strategy meeting pre date national requirements for registration or MAPPA[2]. There was no evidence or information to indicate that 'child 1' nor any other child is in contact with X but to ensure that there is no current risk to children the overview author made a specific recommendation about the individual concerned.

Recommendation five

[2] Multi Agency Public Protection Arrangements; Sections 67 & 68 of the Criminal Justice and Court Services Act (2000) first placed these arrangements on a statutory footing. Sections 325-327 of the Criminal Justice Act (2003) re-enacted and strengthened those provisions. The legislation requires the police, prison and probation services to act jointly as the 'Responsible Authority' in each of the 42 Areas of England and Wales.

All agencies should check their agency records to establish what information is known to them about the current whereabouts of X. This information should be subject of a strategy meeting in the event of X living with or having access to children. The information should also be referred to the officer who co-ordinates MAPPA arrangements in the Vale of Glamorgan for the purpose of assessing whether this individual presents any degree of risk.

3.1.5 Strategy and management of domestic abuse

This case provides a timely opportunity for the strategy and delivery of training in relation to domestic violence to be reviewed. In particular the importance of ensuring everybody dealing with potentially vulnerable women have the knowledge and expertise to identify indicators of abuse and the action to be taken to make further enquiries. Two serious case reviews in 2004 and 2005 recommended that the Area Child Protection Committee (ACPC) reviewed resources for domestic abuse including the assessment of referrals and treatment programmes for perpetrators.

Recommendation six

That LSCB ensure a review of the domestic abuse strategy takes place and that this incorporates an examination of training. This review should take account of action taken in response to previous recommendations from serious case reviews. The review should also ensure that appropriate arrangements for auditing compliance with protocols for identification of domestic abuse, assessment and referral arrangements for perpetrators and those at risk of abuse.

3.1.6 Medical examination

Of critical importance in this case is the consultant paediatrician's decision to organise a range of tests that included x-rays and bone scan that identify the injuries to 'child 1'.

The value of the tests is evident in this case. The lead nurse had the benefit of direct observations from staff regarding the handling of 'child 1' on the ward. She provided a compelling case about the high possibility of undetected injuries. It demonstrates the importance of practitioners with direct knowledge or observation of the child and family participating in strategy meetings.

Recommendation seven

The National Health Service should review whether any additional advice should be provided to consultants and ensure that details of this specific case and the value of x-rays and bone scans

highlighting an undetected injury is made available to other LSCBs in Wales.

3.1.7 Conduct of the Serious Case Review

This serious case review was seriously delayed. These reviews place considerable demands on agencies, and in particular the individuals, who participate in the process. The nature of a review requires the involvement of senior and experienced professionals who inevitably have many demands upon their time and attention. The administration of a review is also a significant task that needs appropriate resources.

Although a protocol for the conduct of SCRs is being prepared it is imperative that the LSCB ensures that the future conduct of reviews is more effectively resourced and systematically organised to ensure that the reviews provide effective contemporaneous learning.

Recommendation eight

The LSCB should establish a case review panel on a standing basis.

Recommendation nine

The LSCB should ensure that explicit instructions are agreed regarding the circumstances and action to be taken when considering a serious case review. These arrangements should ensure that a case review panel is identified, that it meets to consider the circumstances of a child's injury or death and that a formal recommendation is made to the chair of the LSCB within 24 hours. The chair of the LSCB should ensure that a decision is made as soon as possible and in any event not later than four weeks after the significant event(s) to be examined.

The quality of the (Initial Assessment Reports) IARs is variable. One is of very good quality and provides clear analysis and comment to assist the review. In contrast another provides more limited information and analysis. The agency reviews are a significant task that place considerable demands on people who are already very busy with many responsibilities and demands on their time. The conduct of agency reviews is an agency responsibility and as such each of the services needs to ensure they create the capacity and give adequate priority to the task. These comments are not intended to be a criticism of particular individuals involved in this review.

Recommendation ten

The LSCB should consider as a matter of urgency the arrangements for securing an appropriate level of consistent quality in the

conduct, content and outcome of individual agency reviews. In particular the review should identify what training, guidance and mentoring can assist and support individuals who undertake an individual agency review to ensure their work provides sufficient challenge, examination and analysis to assist an agency to improve practice and policy, and where necessary draw attention to any deficits relating to resources, performance or compliance.

There are inevitably questions raised about the capacity and resources available to the LSCB to adequately support the range of work and responsibilities of the Board expected as a result of national guidance and changes in regulations. Paragraph 4.35 of Safeguarding Children Working together under the Children Act 2004 requires LSCB's to be 'supported with adequate and reliable resources'.

Recommendation eleven

The LSCB should review the current capacity of the Board to undertake the full range of tasks and responsibilities required under the Children Act 2004 and described in national guidance.

3.1.8 Issues for national policy

The paediatrician faced a difficult dilemma in judging whether to subject 'child 1' to radiological test. His decision to do so was in large part a result of the persistence of an experienced nurse specialist on child protection. No guidance or procedures are a substitute for well-informed judgements that will need to be shaped by the personal experience and knowledge of these professionals. Work on revising guidance for paediatricians was already taking place prior to the conclusion of this review.

Recommendation twelve

The chair of the LSCB should write to the Welsh Assembly Government (WAG) drawing their attention to the importance of the radiological examinations in this case to diagnosing injuries that were not visible to physical examination. The chair should invite the WAG to judge whether national guidance is sufficiently clear. In particular guidance should stress the importance of having the evidence of direct observations of the child's physical care and handling to inform a judgement about whether there is reasonable cause for concern about a child's health and well being.