

# Plymouth Area Child Protection Committee

## Serious Case Review for 'JG' Executive Summary January 2006

# Introduction

The purpose of this document is to provide an overview of the outcomes and recommendations of the 'part 8' serious case review commissioned by Plymouth's Area Child Protection Committee (ACPC) into the death of a child.

The aim of a part 8 review is not to assign blame, but to ensure that lessons are learned and recommendations are made to the agencies involved in order to avoid similar situations reoccurring in the future.

In the interest of public immunity names will not be used in this document. Instead an individual's title or the position they held will be sited, for example, mother, child or social services, police.

If you would like further information about part 8 reviews and how they are conducted, please refer to the 'Working Together to Safeguard Children' document published by the Department of Health (ISBN 011 322309 9).

## Brief case history

On 6 October 2003, the child at the centre of this case, was admitted to Accident and Emergency Department at Derriford Hospital with serious head injuries where he was examined by a doctor and confirmed dead.

An initial post mortem established the child had suffered a fractured skull. The mother and mother's partner were arrested on suspicion of murder. Neither offered an explanation as to how the child had died.

A part 8 serious case review was instigated in April 2005 by Plymouth's ACPC (Area Child Protection Committee) and an independent consultant undertook the review which was agreed by Plymouth's ACPC in December 2005.

In the full part 8 review report a write-up regarding family history was included in order to provide the background leading up to the death. A chronology of events from February 2001 to October 2003 was also included in order to provide an account of the work and interactions of the professional agencies involved with the child. Written reports from the following agencies were also used to carry out the review:

- Plymouth Primary Care Trust
- Plymouth Hospital Trust
- Devon and Cornwall Constabulary
- Plymouth Hospitals NHS Trust
- CAFCASS

The report details that Social Services were not involved with the family until after the death of the child.

It was from this evidence that the recommendations and lessons to be learned highlighted in the part 8 review were identified. Those recommendations form the content of this summary.

## Lessons learned and recommendations

The findings of the review show that from the evidence seen, there were no clues at all to show that the mother had a new partner. The new partner did not inform anyone of his change of circumstances, and his family chose not to share this information with the CAF/CASS worker who was involved with his family.

The CAF/CASS worker did enquire as to whether there were changes in the man's circumstances but he chose to withhold information that he had established a new relationship with a vulnerable mother and her children. Had this information been shared, it would have triggered an immediate referral to Social Services.

The report highlights that the partner was known to the police, having been reported by his former wife for domestic violence and threats to kill. No assessment had been completed as to the risks he posed and the likelihood of further repeated aggressive acts. He had received no anger management treatment.

The importance of gathering a case history cannot be underestimated as it provides context to the current information. Very little was known about the mother's family background. The Health Visitor notes were extremely brief, focussing only on facts, with little evidence of her taking a holistic approach to, or assessment of the family situation.

Consideration should have been given to the vulnerability of this young mother with two children (each child having a different father) who was known to have had three short-term relationships. There was no mention of the mother's past relationships or whether the children's respective fathers were still involved. No clarification was sought as to whom the mother was fleeing domestic violence from when this was shared with the Health Visitor. This could have been a vital piece of information.

The recommendations below highlight the key areas for improvement identified in the part 8 review report:

### **Individual agency recommendations**

### **Recommendations for Devon and Cornwall Constabulary**

- Devon and Cornwall Constabulary should be more proactive in recording risk factors when attending domestic violence incidents where children are present. Incident reports should be focused on identifying risk/welfare issues and a recognised standard risk assessment be recorded.

### **Recommendations for Plymouth Primary Care Trust**

- Health Visitor Case recording – entries in records should have venue, time of contact, who was there and rationale of visit. Following each visit there should be recorded some analysis as to what was observed and discussed.

### **Recommendations for Area Child Protection Committee**

- Plymouth ACPC to review/develop its information sharing procedure and domestic violence policy.

### **Recommendations to all agencies involved**

- The importance of taking a case history, which provides a context to current information is essential. This will assist all agencies in the gathering of information, assessment of need and in the formulation of outcome focussed plans.
- Current family details including new family members/partners should be recorded by all agencies involved with the family.
- The links between domestic violence and child abuse should be understood, by all professionals, through supervision and interagency training.

## **Conclusion**

The part 8 review report found that from the information available there appeared to have been few agencies involved with the family of the child.

The report found that the CAFCASS worker (working with the partner and his own family) regularly liased with other agencies, sharing and requesting key information to assist in the assessment of risk the partner posed in having unsupervised contact with his own children.

As there were no clues at all from the evidence seen, to show that the mother had a new partner, despite enquiries from the CAFCASS worker, a referral to Social Services was not triggered.