

Plymouth Area Child Protection Committee

Serious Case Review for 'MR' 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

The child at the centre of this case died in May 2004 as a result of a serious head injury. On admission to Derriford Hospital the Consultant Paediatrician stated that in his opinion the injuries were clearly non-accidental.

The partner of the child's mother at the time of death was subsequently found guilty of Manslaughter at Plymouth Crown Court in July 2005 and received a custodial sentence.

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 July 2000 to May 2004 was also included in order to provide an account of the work and interactions of the professional agencies involved with the child. Interviews with the members of staff involved were conducted and access to files were granted. Written reports from the following agencies were also used to carry out the review:

- Plymouth Primary Care Trust
- Plymouth Hospital Trust
- Social Services Department
- Devon and Cornwall Constabulary

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

Based on the evidence of the case records and interviews with the staff involved, the report highlights that it appears managers and social workers have struggled to determine the nature of this case and the inherent risks within the family.

There were clear child protection issues and social services should have at least called a multi agency meeting to consolidate concerns and decide next steps.

The police acknowledge they had information that would have been relevant concerning possible 'risk' to the children and should have passed this information to social services (identification of the mother's new partner).

The review discovered that there was little evidence of a clear health visiting plan for the family. There were recordings where health staff were concerned about attitudes towards the children. It would have been appropriate for the staff concerned to share this with their supervisors or make some tentative enquiries with social services but neither happened.

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

Individual agency recommendations

Recommendations for social services

- All referrals relating to child protection concerns **will** progress to an initial assessment including the completion of all relevant agency checks to inform the manager whether thresholds are met for progression to a Section 47 enquiry (a section 47 means that social services must carry out an investigation when they have reasonable cause to believe that a child living in their area has suffered or is likely to suffer significant harm).
- Need to reinforce the necessity of reading all previous case files before and during intervention as part of their assessment.
- A chronology to be integrated on all case files.

- To ensure that all health staff are part of any core assessment on young children which is initiated by social services.
- Team leaders to audit six files per month as part of a clear audit process within social services.
- Recording procedures to be reviewed.
- Team Leaders to be more accountable for their staff.
- More emphasis on child centred model of assessment and intervention.

Recommendations for Plymouth Primary Care Trust

- Need to reinforce the necessity of reading all previous case files before and during intervention as part of their assessment.
- All health visitors to attend the basic child protection training course.
- Recording procedures to be reviewed.

Recommendations for Police

- To adopt a proactive approach to raising awareness of child protection and the identification of 'risk' factors when dealing with any incident.
- Child incident reports should be more focussed on identified risk/welfare issues and a recognised standard risk assessment should be recorded.
- To ensure systems are put in place to ensure that the submission of a 121a (child incident report) prompts the 'link' between the child's nominal record and the nominal record of those identified as parents/carers/significant adult.

Recommendations to all agencies involved

- A child protection conference should be convened when there is concerns/evidence that the child is suffering or likely to suffer significant harm by **any** agency.
- Supervision notes about individual cases to be retained on the case file.
- All children who have been injured where non-accidental injury is suspected to be examined by a Paediatrician. When this is not appropriate a team leader (in social services) to record reasons.

- The issue of gender and risk from women should be specifically addressed by way of a training programme for all staff.

Conclusion

The report finds that there was not a point at which the thresholds had been reached where the child should have been taken away from the mother's care, but with the appropriate assessment and intervention, the mother might have been equipped to protect the child from her partner at the time of the child's death.

Certainly had all of the information been shared by the professionals a number of factors associated in research as significant indicators of child abuse could have been identified.

The report showed evidence that many of the social workers, health visitors, teachers and team leaders involved in the case attempted to provide a work programme that supported the children. However, too often this work was fragmented and without the benefit of clear analysis or robust tightly timed interventions.

To conclude, the part 8 review report highlighted that there were a number of lessons to be learned as a result of the case in question. It may seem from the report that social services were the main focus in terms of accountability but the investigator held the opinion that 'other services could have been more diligent and proactive in their dealings with the family. All agencies have a responsibility to protect vulnerable children'.