

Plymouth Area Child Protection Committee

Serious Case Review for 'PB'
Executive Summary
May 2005

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 2002 shortly after being admitted to Derriford hospital. The cause of death was pneumonia, dehydration and malnutrition.

The child's mother and partner were subsequently jailed after pleading guilty to child cruelty.

A part 8 serious case review was instigated on 23 August 2004 by Plymouth's ACPC (Area Child Protection Committee) and an independent consultant undertook the review which was completed by December 2004. The final report was agreed by March 2005. Reasons for the time delay in the instigation and completion of the part 8 review will be covered in the recommendations section of this summary.

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 family being involved with Plymouth Social Services. A chronology of events from September 2000 to July 2002 was also included in order to provide an account of the work and interactions of the professional agencies involved. Interviews with the members of staff involved were also conducted.

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 for this summary.

Lessons learned and recommendations

All the agencies involved in this case worked hard to provide support and advice to the family in question. There was regular contact with the family, continual support offered and a good multi-agency approach.

However, the child in question died as a result of neglect by mother and partner, so despite the enormous amount of time, effort, commitment and resources put into the family by various agencies, the part 8 review concluded that there was a fundamental failure to protect the child from significant harm.

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

Individual agency recommendations

Recommendations for Social Services

- Core group minutes should have a format covering all aspects of the protection plan with future actions outlined, and copies of this should go to the relevant managers and line managers for the purpose of supervision meetings between managers and staff
- The Child Concern Model Framework for Assessment should be in operation
- Every case conference for a child where drugs are thought or known to be used by a parent or carer must involve the drugs service
- Social Workers need regular updating on drugs issues as part of their mandatory training/development plan
- All staff should be able to demonstrate and evidence child focused practice
- Where there is a family with complex needs like this one, practitioners should share the responsibility of working with the family and supervision needs to reflect this, shared agency supervision should also be considered
- Where families are being visited on an almost daily basis, practitioners need to reflect on this and take appropriate action, through supervision

- Team Leaders should attend Child Protection Case Conferences to ensure they hear all relevant information
- All Managers must take responsibility for services and ensure systems are in place to monitor and track case work
- The supervision process needs to be reviewed to ensure robust and safe supervision is in place for all staff and in particular those dealing with child protection work
- File audits should be part of the supervision process. Senior Managers must be involved in the process as it is set out in the Victoria Climbié recommendations
- The child protection training needs to be reviewed and a training needs audit should be completed on all staff on a regular basis
- Social Service staff need training to help them understand the indicators for children not being fed, for example, children having cold hands and feet and frequent non attendance for important health appointments in neglect cases
- Assessments and recordings of parent's behaviour when visiting their children in the hospital ward needs to be clearly documented

Recommendations for Primary Care Trust

- The assessment framework is a multi-agency tool and as such should be incorporated into the assessment process to ensure that there is a truly multi-agency assessment
- Health Visitors need regular updating on drugs issues as part of their mandatory training/development plan

Recommendations for School Health Service

- The assessment framework is a multi-agency tool and as such should be incorporated into the assessment process to ensure that there is a truly multi-agency assessment

Recommendations for General Practitioner

- Primary Care teams should actively encourage GPs to attend Child Protection Conferences and where attendance is not possible to always submit a written report

Recommendations for Hospital Services

- Paediatricians should consider making a distinction between a medical diagnosis and any concerns that they have regarding the social construct of a child's environment when preparing reports for case conferences

Recommendations for Community Drugs Service

- It is important to involve the Community Drugs Service in any case where drug abuse is suspected
- Protocols need to be developed about the testing of all children in families where a baby is born with drug addiction withdrawal symptoms

Recommendations for Education

- It is important for educational professionals to follow up any concerns to Social Services, whilst it was not a requirement at the time it is now standard procedure. The designated Child Protection lead within Life Long Learning is a useful point of contact for support and advice

Recommendations for Police

- Chief Constable to make clear that the Devon and Cornwall Constabulary regards the protection of children of paramount importance
- An awareness exercise with the Devon and Cornwall Constabulary that those children in the custody of drug abusers are a vulnerable group and officers to be aware of issues of possible neglect
- To ensure the Constabulary adopts a proactive approach to the completion of child protection reports (form 61 and form 121a) following incidents

Recommendations for Housing

- Housing have requested a proactive practice in future situations

Recommendations for ACPC Serious Case Review

The ACPC has the responsibility to ensure the following recommendations are completed and that a process should be in place to monitor the progress of the agencies involved.

- Complex cases should have more than one worker assigned to a family
- Social Workers and Health Visitors managing complex cases should have consistent supervision where possible
- A review of management support and supervision procedures available to Social Workers needs to be undertaken
- Specific supervision protocols for Social Workers and Health Visitors involved with 'dangerous families' needs to be developed
- Objective ways of recording an accurate description of the state of cleanliness and untidiness of the inside of a house in cases of neglect needs to be developed
- Formal multi-agency assessments of families must be undertaken in cases of suspected neglect to enable progress or otherwise to be measured. The new assessment framework will assist with this

General recommendations to the ACPC

- Serious Case reviews should be undertaken within four months unless an alternative timescale has been agreed with the Commission for Social Care Inspection (CSCI)

Complexities of this case, including criminal proceedings and the Coroner's request for open access of the part 8 report, contributed to the delay in the review. However, the Chair of the ACPC wrote to CSCI on four occasions over a period of four months with no reply. The Chair of the ACPC also wrote to the Coroner on more than one occasion requesting clarity and confirmation of his intent to pursue the release of the part 8 report and this has contributed to the delay. Therefore the required actions were completed by the ACPC.

- ACPC should be chaired by Social Services to ensure the appropriate expert takes the lead in child protection matters

Recommendations to all agencies involved

- Every parent with any form of drug dependency needs to have a multi-agency antenatal assessment and should be thought of as a chaotic drug user until proved otherwise
- The supervision process to be reviewed to ensure robust and safe supervision for all staff with a particular focus on those dealing with child protection
- Training needs audit to be completed on all staff with specific focus on neglect and drug abuse
- All staff and Managers to receive update training on Assessment Framework
- It is important to ensure that the sharing of any health concerns by medical professionals is clearly understood by other professionals and that consideration is always given to reaching mutual understanding of all parties concerns when preparing and discussing reports for case conferences

Conclusion

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 also suggested that as a result of the time delay between the incident taking place and the review being completed that a number of recommendations outlined in the part 8 report have since been implemented. For that reason this summary concludes with a list of the actions already undertaken.

Implemented changes

- Improvements to the process of Serious Case Reviews in Plymouth. A Serious Case Review sub-committee is now chaired by Social Services (Assistant Director for Children and Families) and occurs currently on a monthly basis
- The review process now includes an initial 24 hour rapid response by agencies to look at any immediate action/changes in working which need to occur following the report of a critical incident
- The police have agreed to take responsibility for first notification of critical incidents, as they are often one of the key agencies to be involved at an early stage
- A tracking document has been designed for agencies to record completion of internal chronologies of actions and production of any single agency management actions required
- An external contract has been negotiated with NSPCC to independently undertake multi-agency composite chronologies and overview reports
- Plymouth ACPC will change to a Safeguarding Board, operating under the Children and Young Person's Strategic Partnership from summer 2005
- Learning from previous Serious Case Reviews has formed part of a training programme to be rolled out across a multi-agency group
- A peninsula wide day has been organised and delivered by the Designated Doctor for Child Protection to look at a shared approach to learning from Serious Case Reviews
- Plymouth Social Services are using an external training agency to develop an action plan for training delivery to

ensure that key training needs identified through Serious Case Reviews are addressed

- Plymouth Hospitals Trust and Plymouth Primary Care Trust have implemented a number of changes in relation to updating training on the Assessment Framework, reviewing supervision and have also begun work on a training needs audit
- All agencies in Plymouth have implemented the Child Concern Model, including the Framework for Assessment