



# **Plymouth Safeguarding Children Board**

## **Executive Summary**

**M**

**July 2008**

**Public Document**

# Plymouth Safeguarding Children Board Serious Case Review

## Introduction

The purpose of this document is to provide an overview of the outcomes and recommendations of the serious case review commissioned by Plymouth's Safeguarding Children Board into a serious incident involving a child.

The aim of a Serious Case 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 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 cited, for example, mother, child or Children's Social Care services, police.

If you would like further information about Serious Case 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 was the second child born to the family. The child was discharged into the care of the parents, shortly after birth. Within three weeks, the Health Visitor noted bruising to the baby and referred to the General Practitioner ( GP ), and consulted with Children's Social Care.

Further bruising was noted over the next two weeks and the GP, Health Visitor and Children's Social Care Social Worker liaised over possible causes and deemed the bruises to be explainable.

At six and a half weeks old the baby was again presented to the GP as unwell, by the parents, who were referred to the local hospital for further investigation.

It was discovered that the baby had sustained fractured ribs.

At this point a Serious Case Review was initiated. The Terms of Reference for the Serious Case Review were:

1. The Internal Management Report will concern itself with the agency involvement of mother's pregnancy with the child, until the diagnosis of serious injuries to the infant. This will include any relevant background information about the family.
2. The Report will identify adherence to the individual agency procedures, with particular attention to the recording processes and the quality of assessment and response.
3. The report will consider the effectiveness of multi agency working to safeguard and protect the child.

### **Lessons learned and recommendations**

Following the completion of the Overview Report a number of lessons were identified:

1. Agencies did not follow Child Protection Procedures.
2. Errors were compounded, by a lack of vigorous management oversight.
3. There was an over reliance on the General Practitioners expertise of Child Protection.
4. There was confusion over whether the Health Visitor was making a Referral or requesting a Consultation. There was also lack of clarity as to whether an Initial Assessment had been conducted.
5. There was a lack of clarity because historical information on the family, was not collected.
6. The historical information about the family was not easy for workers to find or access.

## Individual agency recommendations

### **Plymouth teaching Primary Care Trust**

- A process for formal face-to-face communication about clinical issues between Health Visitors and General Practitioners will be implemented.
- A Child Protection Training needs analysis for General Practitioners will be undertaken.
- The transfer of clients from PHNT Midwifery Service to PtPCT Specialist Community Public Health Visiting Service will be reviewed to ensure that vulnerable children and those in need of protection, are clearly identified.
- All Specialist Community Public Health Visiting Service staff, Supervisors and Managers will receive regular updating in Child Protection and systems. This will be in place, to quality assure staff's basic Child Protection awareness.
- Specialist Community Public Health Nurses to access training in working with dangerous families.
- Specialist Community Public Health Nurses to access training in respect of Child Protection, analysis and decision-making.
- Specialist Community Public Health Nurses to ensure that a working knowledge of the multi-agency Child Protection Handbook and PtPCT Child Protection policies are embedded in practice and that this is quality assured.

### **Children's Social Care**

- The Service Manager for Advice and Assessment will ensure that the Multi Agency Child Protection Handbook is followed for all child protection issues.
- The Service Manager for Advice and Assessment will ensure that all workers in the Service are aware of the difference between a Consultation and a Referral.

## **Children's Social Care (continued)**

- The Service Manager Advice and Assessment will instigate procedural changes, to ensure that all referrals are opened on the day they are received.
- Managers will ensure that the social worker has carried out all directed actions on a case.

## **Plymouth Hospitals National Health Trust**

- The Midwifery service should ensure that information contained in a mother's medical record that could indicate a possible risk or vulnerability factor for the baby should be taken account of, antenatally.
- The transfer of clients from PHNT Midwifery Service to PtPCT Health Visiting service should be reviewed, to ensure that vulnerable children and those in need of protection are clearly identified.

## **Recommendations for all agencies involved**

- Action will be taken to ensure all relevant agency staff have a thorough understanding of Child Protection Procedures.
- Individual agencies will ensure their staff understand that compliance with Child Protection Procedures is compulsory.
- A section in the local Child Protection Procedures will be produced to determine what action is taken when a dispute or disagreement arises between professionals.
- Agencies will take steps to ensure the quality of recording and notes taken in child protection cases is improved.
- There will be a review of the advice provided to professionals in regards to consultation and referrals, to ensure that all staff working with children understand the difference.
- It is essential that in the future, where concern exists about the safety of a child, investigations are always pursued to a point

where it is agreed between the professionals involved that the child's safety is secured.

## **Conclusion**

To conclude, the Serious Case Review overview report highlighted that there were a number of lessons to be learned as a result of the case in question.

### **1. Management of Child Protection Referrals and Investigations**

- At the point of referral to Children's Social Care it should be established and understood by all agencies involved that Children's Social Care has the primary responsibility to co-ordinate and investigate any concerns.
- Social workers and their managers must understand their primary responsibility in regard to co-ordinating and investigating any child protection concerns and take effective action to achieve this objective.

### **2. Multi-Agency Child Protection Procedures**

- Individual agencies should ensure their staff understand that compliance with Child Protection Procedures is compulsory.

### **3. Professional disagreement and disputes**

- The Resolving Professionals Differences Policy will be included in the Child Protection Procedures. It will be clear what action is taken when a dispute or disagreement arises between professionals.

### **4. Recording and medical notes**

- Consideration should be given to improving the quality of recording/notes in child protection cases.

## **5. Consultation/Referral between agencies**

- All Professionals must be aware of the difference between Consultation and Referrals.

### **Implemented changes**

#### **Individual agency recommendations**

##### **PtPCT**

Formal face to face communication has been set up between Health Visitors and GP's.

Following a training needs analysis, a training programme has been developed and started for GP's .

The PCT are currently implementing their Child Protection Strategy.

##### **Children's Social Care**

A briefing note has been sent to all managers and Senior Practitioners in Advice and Assessment reminding them of the importance of following Child Protection Guidance, this is measured by monthly audit.

The Service Manager has circulated the Improvement Plan which identifies the need to ensure that referrals are opened on the day they are received.

Managers ensure that social workers carry out directed actions, compliance is measured at the Advice and Assessment Meetings.

### **Recommendations for all agencies involved**

Both Children's Social Care and PtCT staff working with children have a thorough understanding of Child Protection Procedures. Briefing notes have been sent to all staff and in Children's Social Care monthly Referral audits ensure compliance.

PtCT staff are assessed by audit, supervision and recorded training records.

The Plymouth Safeguarding Children Board have produced guidance on how to resolve professional differences.

The quality of recording/notes has been addressed in PtCT by audit trail and Supervision. The quality of recording in Children's Social Care is now audited by the Team Managers.

A briefing note has been sent out to staff in Children's Social Care to ensure a full understanding of the difference between Consultation and Referral. The new Common Assessment Framework is being rolled out to professionals in the city.