



Executive Summary
of
Serious Case Review

Child P

Introduction

- 1.1 Working Together to Safeguard Children (2006), Chapter 8, requires that Local Safeguarding Children Boards give consideration to conducting a serious case review where:
“a child sustains a potentially life threatening injury or serious and permanent impairment of health and development through abuse and neglect”.
- 1.2 The purpose of the review is to establish whether there are lessons to be learned locally from the way in which professionals worked together to safeguard the subject child; to identify those lessons clearly and comment on how they will be acted upon to promote improved inter-agency working.
- 1.3 Working Together to Safeguard Children (8.33) requires that each serious case review produce an Overview Report of its findings and that this should contain an Executive Summary. This latter document is available to the public and contains anonymised details of the child and his/her family, information on the review process, key issues arising from the case and any recommendations that have been made.
- 1.4 Child P suffered serious non accidental injuries. The matter was considered at the RBSCB Case Management Sub-Group in August 2007 and it was agreed that the circumstances met the criteria for conducting a Serious Case Review.
- 1.5 The Overview Report of the Serious Case Review Panel was completed in January 2008, with additional consideration being given to the findings in June 2009.

1. Process of the Review

- 1.1 The Terms of Reference for the Review are as follows:
 - To receive Individual Management Review reports from key agencies involved with Child P and her family;
 - To establish the facts of what was known to agencies for the period covering Child P’s birth to her admission to hospital;
 - To appoint an Independent Chair;
 - To consider to what extent family members were able to contribute to the review process and what form this should take;
 - The Serious Case Review Panel to include representatives from:

Rochdale Child Care Service
Heywood, Middleton & Rochdale PCT
Pennine Acute NHS Trust
Greater Manchester Police
Rochdale Safeguarding Children Board;

- To produce an Overview Report and Executive Summary within agreed timescales;
- The key lines of enquiry to consider:
 - the interagency response to incidents of domestic violence;
 - the strength of interagency processes for identification and risk assessment of adults who pose a risk of harm to children;
 - the quality of assessments in relation to children who present with injuries;

1.2 The following agencies undertook Individual Management Reviews:

- Pennine Acute Trust (Midwifery)
- Pennine Acute Trust (Nursing)
- Pennine Acute Trust (Medical)
- Heywood, Middleton & Rochdale PCT (Health Visiting)
- Greater Manchester Police
- General Practitioner
- Rochdale Child Care Service (Duty & Assessment Team)
- Rochdale Child Care Service (Emergency Duty Team)

Additionally the Probation Service was asked to contribute any additional information.

2. Summary of Events

- 1.1 Child P lived initially with her mother and birth father with the paternal family. Child P was well cared for as a baby and there were no concerns about her health and development.
- 1.2 The parents' of Child P ended their relationship. Following the separation, Child P's mother became involved with a new partner. The police attended a call for assistance when Child P's Father attended the address of her mother alleging that her new partner was a rapist.
- 1.3 During a visit to the family home in the summer, a Police Officer observed bruising to Child P and grazing to her face. The mother of Child P said that she had had an accident and had been seen by her GP. Initially, the Officer accepted the explanation, but after further thought decided to inform Child Care Services Emergency Duty Team.

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- 1.4 As a consequence of the referral from the Police Officer, a Social Worker attended the family home and observed Child P's injuries. Concerned at the extent of Child P's injuries, the Social Worker liaised the local hospital Children's Ward to seek a medical opinion. The Social Worker was advised that Child P should attend Accident and Emergency where she was later seen and her injuries were felt to be consistent with the explanation offered by her mother.
 - 1.5 Approximately three weeks later, Children's Social Care were contacted by Child P's maternal grandmother who reported that she had not seen Child P for some time, but that when last seen, Child P had bruising to her back and face. The maternal grandmother also expressed concern about the conduct of Child P's current partner. The Social Worker involved made an assumption that the bruises referred to were the ones that had been seen by a Social Worker and medical staff previously and had been accepted as accidental in origin. As a consequence, The Social Worker responded to the maternal grandmother by giving advice about family mediation. The Social Worker accessed the Children's Social Care information system and believed Child P's case was an open case and, as a result, made only brief notes about her contact with the family, rather than a new referral.
 - 1.6 Two days later, Child P's aunt contacted Greater Manchester Police and stated that she had been threatened by Child P's mother's partner. The Police attended the Aunt's home and she again reported concerns about the bruising she had seen on Child P when she had last seen her niece. The Police initially had some difficulties in locating Child P, but when they did she was seen to be heavily bruised and was taken to hospital. The mother's partner was arrested on suspicion of child cruelty.
 - 1.7 On examination, Child P was found to have extensive bruising and swelling to her face, bite marks on her shoulders and upper limbs, bruising to her left leg, infected fingers, haemorrhage to her right eye and fractures to her ribs and left tibia and fibula.

3. Key Issues

- 1.1 The Review identified three significant missed opportunities to respond to the presenting needs of Child P which could have resulted in a more detailed assessment of her circumstances which may have identified her as a child in need or a child at risk of harm. The first instance was when Child P was noted to have a black eye by a GP and Health Visitor whilst visiting the surgery and they did not follow Child protection procedures; the second instance was on the first occasion when Child P was presented at hospital for examination she was seen by a doctor in Accident and Emergency rather than a paediatric specialist with greater knowledge of child protection, and the third instance was when her grandmother contacted Children's Social Care concerned about her welfare the Social Worker did not undertake an Initial Assessment.

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- 1.2 The circumstances within which Child P became known to agencies other than universal services escalated quickly. Child P was 26 months old when she was first known to Children's Social Care, twenty four days before the very serious injuries were discovered.
 - 1.3 The very limited time between when Child P was first observed with an injury by the GP and Health Visitor to when she was severely injured demonstrates the crucial need for practitioners to act quickly and within professional procedures on every potential indicator of concern and risk. In particular Child P was a very young child who was unable to provide an account of what was happening to her, and professionals should have been alerted to her additional vulnerability.
 - 1.4 Child P first came to the attention of the police when she was twelve months old. The Police attended three requests for assistance due to incidents of domestic abuse between her parents. The Review demonstrates the importance of the Police response to domestic abuse as the agency who are generally the first responders and the importance of the police role in identifying and ensuring a multi agency response to those children who are at risk from the effects of domestic abuse.
 - 1.5 Although little information was known to agencies about Child P's family, her father and members of her extended family were clearly concerned about her safety and these concerns were brought to the attention of both the police and Children's Social Care. This review reminds practitioners of the importance of listening to family members, and the dangers of assuming motivation.
 - 1.6 When Child P was taken to hospital by her mother as arranged by the Emergency Duty Social Worker she was examined by a general doctor in the Accident and Emergency Department. Given the circumstances of the visit to hospital, in accordance with Child Protection Procedures, Child P should have been seen by the Paediatric Registrar on the Children's Unit, and staff on duty in Accident and Emergency should have ensured this happened.
 - 1.7 Agencies had limited knowledge about Child F in the context of her family relationships. Prior to the injuries, there were thirty four health visiting contacts with Child F but only two of these visits took place in the child's home. The Initial Assessment undertaken by Children's Social Care when she attended Accident and Emergency contained no specific information about her father or the presence of other males in her life. Family members provided sensitive information about Child P's mothers partner which raised some concern but which was insufficiently checked out. The Biennial Analysis of Serious Case reviews 2005 – 2007 confirms that there is a dearth of information about men in many Serious Case Reviews, alongside a failure to take fathers and other men connected to the families into account in assessments.
 - 1.8 When the police were alerted to concerns about Child P by her Aunt, they acted tenaciously to locate her. When they did so, they acted decisively in

seeking medical attention for Child P and arresting and charging the person they believed was responsible.

4. Recommendations

5.1 Pennine Acute Trust

1. Ensure that all children referred by a Social Worker (for whatever reason) are seen by a Paediatrician;
2. Develop a policy which allows all consultations from outside agencies to be recorded whether there is any subsequent involvement or not;
3. Review guidance to examining doctors to remind them of their wider safeguarding duties and to ensure they undertake holistic assessments on children and routinely use body maps to record their findings;
4. Introduce a requirement that examining doctors 'sign-off' the information provided by triage nurses.

5.2 Rochdale, Middleton and Heywood PCT, Health Visiting

1. Staff must adhere to NHS HMR record keeping policy; training and supervision should reinforce this, and record keepings audits should monitor;
2. The organisation needs to include children's ethnic, cultural, linguistic and religious needs;
3. Child protection supervision should discuss and monitor the frequency of home visits.

5.3 Rochdale, Middleton and Heywood PCT, GP

1. Any request from a social worker for a professional assessment/medical examination on a child with an injury will trigger the child protection policy NCWC004 for the management of suspected child abuse for medical staff;
2. All referrals for a medical examination / assessment by a Social Worker/ Police will be taken and facilitated by the Consultant Paediatrician or the Paediatric Registrar in consultation with the Consultant Paediatrician on-call. This referral will be documented in the child's medical records.
3. No child referred by a social worker for a Child Protection Medical should be seen/examined in the Accident and Emergency Department. Arrangements should be made to examine the child on the Children's Unit or within the Children's Outpatient Department. However, if the child requires medical treatment this would be dealt with according to clinical need.
4. Breaches in Safeguarding Policies will trigger the EDQ008 Accident & Incident Reporting Policy
Where a member of Staff continues to breach Safeguarding Policies this will trigger the following:

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- EDH002 Conduct and Disciplinary Policy
 - EDH010 Disciplinary Procedure for Medical Staff

5.4 Greater Manchester Police

1. Ensure that all Officers are aware of the reporting procedure for out-of-hours concerns to EDT and PPIU;
2. Review the policy on reporting and recording Officers' work to allow a means to add child protection concerns not included at the time of the original record;
3. Emphasise to staff their wider safeguarding role when discharging their duties and the need to make accurate records of their involvement with families;
4. Review the script used by civilian call takers to include questions about child safety whenever calls are received relating to violence or sexual offending.

5.4 Children's Social Care

1. Ensure that the same threshold of intervention in relation to child protection concerns applies whether those concerns arise during working time or out-of-hours;
2. Ensure that the information system to which EDT workers have access contains accurate, up-to-date information regarding the status of every case (open, closed, pending, etc);
3. Review the recording and reporting policy for EDT staff to ensure all referrals and consultations on children for medical assessment are confirmed by fax or e-mail.

In addition, Rochdale Children's Social Care has reviewed the EDT provision in relation to children and young people. The generic EDT service has been reorganised and will become service specific and operational in October 2009. The new out of hour's provision for children and families will become part of the operational duty and assessment team giving 24 hour provision of service.

5.5 Recommendations made by the Serious Case Review Panel

1. Review the single and multi-agency training strategy to ensure that staff in all agencies receive appropriate information on child abuse/neglect awareness and guidance on what to do if abuse/neglect is suspected;
2. Specifically from this Special Case Review, it is recommended that particular attention is paid to the needs of Police Officers and medical practitioners and that arrangements are made for their training which are flexible and operationally achievable;

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3. Rochdale Safeguarding Children's Board give support to the appointment of a Designated Doctor for the Borough and a Training Officer for the Pennine Acute Hospitals NHS Trust;
 4. The Chair of the Rochdale Safeguarding Children's Board to raise with the Chief Executive of Heywood, Middleton & Rochdale PCT the issue of medical practitioner engagement in the safeguarding process;
 5. Rochdale Safeguarding Children's Board agree that gaps in best practice identified in the course of Serious Case Reviews should be acted upon immediately (through either implementation or consultation) and reported back to the next Board meeting.