
Serious Case Review
Executive Summary
Re: Child T

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Childcare Management Systems

1. Introduction

1.1 This report is a summary of the findings of a Serious Case Review (SCR) that was undertaken to critically examine the role of agencies involved with Child T and his family in the period leading up to his death. The SCR also considered the way agencies responded to the needs of other children in the family after Child T's death.

1.2 When Child T died, he was already the subject of safeguarding concerns and was awaiting an initial Child Protection conference. Following his death, Child T was the subject of a post-mortem examination which concluded that the cause of death was unascertained. However, the examination revealed numerous injuries to Child T's head, face and body that were highly suggestive of non-accidental injury (NAI). At the time of Child T's death the process to determine whether a SCR was necessary in the case of a child death was directed by the guidance contained in Working Together (2006) which states:

LSCB's should always consider whether a SCR should be conducted where:

- ◆ a child sustains a potentially life-threatening injury
- ◆ a child has been subjected to particularly serious sexual abuse
- ◆ a parent has been murdered
- ◆ a child has been killed by a parent with mental illness
- ◆ **the case gives rise to concerns about inter-agency working to protect children from harm**

1.3 When Child T died Ofsted were informed on the following day. There was a meeting of the RBSCB Case Management Sub Group (CMSG) which was advised about the circumstances of Child T's death and informed that the outcome of the preliminary post-mortem was that the cause of death was unascertained. The meeting was provided with limited information about the extent of Child T's suspicious injuries. The meeting was divided about whether the criteria for holding a SCR was satisfied and it was decided to defer the decision about a SCR pending the outcome of the full post-mortem. There was some delay in this becoming available and the decision to hold a SCR. Ofsted were informed. The Review Panel was critical of the CMSG for deferring the decision about a SCR. It felt the criteria for holding such a review were satisfied and the decision not to proceed at that time introduced unnecessary delay into the learning from this Review.

1.4 When Ofsted were first notified of the intention to conduct a SCR, a date for completion was set. However it was necessary to notify Ofsted on three occasions about the need for extensions to the timescale for the Review. The first extension was to allow IMR authors to review the single agency chronologies following a decision to extend the timeframe for the SCR and also to request an IMR from the Nursery that Child T had attended. The second extension was to allow time for CAFCASS to prepare an IMR and for the Panel to make contact with family members (having been advised not to do so by the Crown Prosecution Service pending a decision on criminal proceedings). The third extension was necessary to accommodate the delay in the 'Finding of Fact' hearing that was made in the civil proceedings on Child T's older sibling, Child P.

Each of these extensions were discussed with Government Office North West (GONW) who agreed that the reasons for the delays were acceptable and the additional contributions (from the Nursery and CAFCASS) would clearly add to the overall learning from the SCR. Ofsted were then notified of the final completion date

2. Circumstances that led to the Serious Case Review

2.1 Child T began to attend a local Nursery on a part-time basis to allow his mother to access work experience training. During the course of a nappy change, he was seen to have seven greenish bruises to his back and abdomen. These were brought to the attention of the Room Leader, who following consultation with the Nursery Manager, spoke to Adult F about the bruises when he collected Child T later that day. Adult F gave two different explanations for Child T's injuries which were accepted and recorded. No further action was taken by the Nursery.

2.2 On the following week, once again during a nappy change, Child T was seen to have further bruising to his abdomen and he also had bruises to both sides of his forehead. The Nursery Manager consulted with Child T's Health Visitor and she then made a referral to Children's Social Care (CSC). She did not report the concerns of the previous week at that time.

Upon receipt of the referral CSC held a strategy meeting with two Officers from the local Public Protection Investigation Unit (PPIU) and a decision was made to conduct a S.47 enquiry. A visit was made to Adult L to inform her of the concerns about Child T and to request that she take him for a medical examination.

2.3 Child T was presented at a local Hospital later that day where he was examined by a Paediatric Registrar who had been made aware of the similar bruising seen on Child T a week earlier. In the course of the examination (and in earlier discussions with CSC and PPIU) Adult L and Adult F offered a number of different explanations for Child T's various injuries.

The outcome of the medical examination was inconclusive. The Registrar was not able to say that Child T's injuries had definitely been inflicted, but he was sure that the most recent bruises could not have been caused by tickling (one of Adult L's explanations). On the basis of this diagnosis, a decision was made to allow Child T to return to his mother's care.

2.4 The Registrar wrote to CSC to report the outcome of his examination. The letter recorded that NAI could not be ruled out as an explanation for Child T's injuries. The Social Worker involved in the case spoke to a Consultant Paediatrician who was of the view that Child T's injuries were certainly the result of inflicted injuries. The Social Worker did not report either of these pieces of information to the PPIU.

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- 2.5 The Social Worker had been reluctant to take any further action on the case but was persuaded to do so by the Registrar's letter and her conversation with the Consultant Paediatrician. She arranged an initial case conference and made an arrangement to visit Adult L later on to discuss the upcoming conference. When she visited, Child T was not present. He was reported to be with his grandparents. The Social Worker did not visit Adult K and Adult J to see Child T, even though they lived close by.
- 2.6 Seven days following this visit Child T was found lying face down in his cot by Adult F; he was cold and unresponsive. He was taken to a local Hospital where he was found to be dead on arrival. An initial examination by the on-call Paediatrician identified suspicious bruising to Child T's face and noted he had a torn frenulum. Child T was the subject of a post-mortem examination the following day which revealed extensive bruising to his head and face, bruising to his abdomen, suspicious bruising to his neck and severe lacerations to both sides of his tongue. All of these injuries were regarded as suspicious but could not with certainty be identified as the cause of Child T's death which it was concluded was unascertained.
- 2.7 The evening before Child T's death, Child P had stayed with her grandparents. When the investigation into the cause of Child T's death began, the Senior Investigating Officer (SIO) decided her interests would be best served if she remained in their care. He did this in the knowledge that Adult K had had care of Child T in the 24 hours before he died. Child P's placement was secured using Police Protection (S.46) Powers.
- 2.8 Following Child T's death CSC attempted to convene a strategy meeting involving the PPIU to discuss Child P's ongoing safeguarding needs, but two requests for attendance were declined. The CSC Team Manager spoke directly to the SIO to express her concerns about Child P's placement. He reassured her that Child P was safe and told her that he was in possession of information about the case which he was choosing to withhold from her at that time. Child P remained with her grandparents.
- 2.9 Ten days after Child T's Death there was a professionals' meeting in line with Sudden Unexplained Death in Childhood (SUDC) procedures at which the full extent of Child T's injuries were revealed. There were three representatives from CSC at the meeting. From the information provided, it emerged that Child T had not only been in his grandparents' care in the 24 hours before he died, but he had also been in their care in the days before he died (when he would have sustained the serious injuries to his tongue). No action was taken to review Child P's placement following the receipt of this information.

2.10 Child P remained in the care of her grandparents. During this time she continued to have supervised contact with her mother at her grandmother's home. This arrangement was problematic throughout and there were numerous incidents of Adult J and Adult L behaving and speaking inappropriately during contact. In the course of the placement also Adult K and Adult J were the subject of a risk assessment which concluded that they did not agree with the Local Authority's view about the need for proceedings and did not believe that Adult L or Adult F had harmed Child T. Despite this negative outcome from the assessment, Child P remained in placement with her grandparents.

This arrangement ended when Child P revealed she had been having daily unsupervised contact with her mother. She was placed with her birth father (Adult M) and his partner.

3. Process of the Review

It was agreed that the Serious Case Review would:

3.1 Originally the timeframe for the Review had been set at until Child T's death. The reason for the extended timeframe was to allow the Review Panel to consider:

- ◆ Adult L's early life experiences
- ◆ The circumstances surrounding Child T's death
- ◆ The way in which agencies worked together to safeguard and promote the welfare of Child P and Child S following Child T's death
- ◆ The decision making about the need for a SCR

3.2 Appoint an Independent Chair and separate Independent Author of the Overview Report. This is consistent with the guidance contained in Working Together (2010). The Chair of the Review Panel was a retired Senior Police Officer. He has had extensive experience in safeguarding work and has been the author of a number of Overview Reports and is the Chair of a Joint Child Death Overview Panel in another authority. He had no contact with Child T's family before or during the SCR.

The Overview Report Author was an independent consultant with 25 years' involvement in child protection work and extensive experience in writing Overview Reports. He had no previous involvement with or knowledge of Child T and his family.

3.3 Consider to what extent family members were able to contribute to the Review and what form this should take. At an early meeting of the Panel it was agreed that it would be useful if contributions could be received from Adult L, Adult F, Adult K, Adult J, Adult M and Adult E. The Panel was advised to delay making contact with any of these people pending a decision by the CPS about whether any charges were to be brought following Child T's death.

At a subsequent meeting the issue of family involvement was discussed further and again the Panel was advised that, even though the decision had been made not to proceed with any charges relating to Child T's death, it would be prudent to further delay making contact with the family pending the Finding of Fact judgement in case this led to a reconsideration of the decision not to bring charges.

The Panel considered this request and was mindful of the need to avoid contaminating any criminal investigation, but felt it was important in this case to invite the family to make a contribution. A compromise solution was agreed whereby the family members identified earlier would be contacted and invited to make a written contribution to the SCR process. The Panel recognised that this was not an ideal solution, but agreed it was the best available in the current circumstances.

The Panel received a written response from Adult K and Adult J. It pointed out a number of poor practice issues that the Panel felt had been addressed either in the CSC IMR or the Overview Report. Other issues raised in the letter were being addressed through alternative courses of action that had been taken by Adult K and Adult J. No other responses were received from any other family member.

3.4 Receive Individual Management Reviews from the following agencies:

- ◆ Greater Manchester Police
- ◆ Pennine Care NHS Foundation Trust
- ◆ Rochdale Borough Council Children's Social Care Services
- ◆ Heywood, Middleton & Rochdale NHS (Health Visiting)
- ◆ Heywood, Middleton & Rochdale NHS (GP Services)
- ◆ Pennine Acute NHS Trust (Midwifery)
- ◆ Pennine Acute NHS Trust (Nursing)
- ◆ Pennine Acute NHS Trust (Medical)
- ◆ CAFCASS
- ◆ Nursery

The Panel received information from the Designated Doctor NHS Manchester regarding the SUDC policy and procedures. The Panel also had access to the draft Finding of Fact judgement delivered in the proceeding in relation to Child P.

The Independent Overview Author was provided with copies of minutes of the CMSG, the SUDC Review Case Discussion of and the confidential Senior Managers' Meeting. He also had access to the post-mortem report and the neuropathology reports.

In order to promote transparency and independence, none of the authors of the IMR's had had any direct line management responsibility for the practitioner involved in this case and none had had previous contact with Child T and his family.

There was an issue relating to the independence of the author of the Heywood, Middleton and Rochdale NHS (Health Visiting) IMR as she had been present at the SUDC meeting and had been a member of the CMSG. She had therefore been involved in the decision to delay the commencement of the SCR of which the Review Panel was critical. The Chair of the Panel wrote to the Executive Director of Integrated Commissioning HMR NHS outlining the concerns of the Panel and offering suggestions provided by GONW on how the matter could be resolved. There has been no response from the Executive Director at the point of writing this report.

3.5 The membership of the Serious Case Review Panel was as follows:

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| ◆ | Mr D Hunter | Independent Chair |
| ◆ | Detective Inspector | Greater Manchester Police |
| ◆ | Safeguarding Lead | Pennine Care NHS Foundation Trust |
| ◆ | Designated Nurse | Heywood Middleton and Rochdale NHS |
| ◆ | Attendance and Safeguarding Manager | Learners and Young People RMBC |
| ◆ | Lead Nurse Safeguarding | Pennine Acute NHS Trust |
| ◆ | Service Manager CWD | Children's Social Care, RMBC |
| ◆ | Business Manager | Safeguarding Children's Board |
| ◆ | Service Manager | CAFCASS |

Mr M Muir, the Overview and Executive Summary Author also attended the Review Panel in the role of participant/observer.

NB

The Chair of the RBSCB at the time of writing this summary is Ms C Eastwood, Director of Children's Services. This is a temporary arrangement, pending the appointment of an Independent Chair, arrangements for which are in hand.

3.6 Consider the following case specific terms of reference:

- (a) To what extent were the indicators of risk present in this case recognised and taken into account by your Agency in the decision-making about Child T and his family?
- (b) Did your Agency adhere to Single Agency and Multi-Agency policies and procedures in this case?
- (c) Did your Agency communicate effectively and work together to safeguard and promote Child T's welfare?

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- (d) Following the incident that led to this Serious Case Review, how did your Agency respond to safeguard and promote the welfare of other children in the family?
 - (e) To what extent did the reaction and response of Child T's extended family to his death impact on the ongoing management of this case?
 - (f) Were there any cultural, linguistic or disability-related needs that needed to be taken into account in providing services to Child T and his family?
 - (g) What key decisions were made by your agency, how and under what circumstances were they made and how were they monitored?
 - (h) Did the staff involved with Child T receive adequate supervision and support and was there sufficient management oversight of the case?
 - (i) Consider whether there are similar issues in this case compared with earlier SCR's, both locally and nationally, and are there common themes present?
 - (j) From the information that was available, could the incident that led to Child T's serious injuries have been predicted or prevented?

3.7 The Review Panel met on 10 occasions

4. Family Composition

Subject
Ethnicity

Child T
White British

Mother
Ethnicity

Adult L
White British

Putative Father
Ethnicity

Adult R
White British

Half Sibling
Ethnicity

Child P
White British

Maternal Grandfather
Ethnicity

Adult K
White British

Maternal Grandmother
Ethnicity

Adult J
White British

Maternal Aunt
Ethnicity

Adult E
White British

Significant Others:

Adult L's Husband
Ethnicity

Adult F
White British

Child P's Father
Ethnicity

Adult M
White British

Maternal Cousin
(Child of Adult E)
Ethnicity

Child S
White British

4.2 Family Profile

- 4.2.1 Adult K and Adult J were the subject of a Family and Friends assessment undertaken by CSC following Child P's placement with them. The assessment revealed that Adults K and J are white, middle-class working professionals who live in a privately-owned property in a quiet suburb of Rochdale. They described their family as sound, warm and supportive and they reported no difficulties in parenting either Adult L or Adult E.
- 4.2.2 Adult L had in fact had a difficult adolescence and there is evidence that her relationship with her parents was strained and problematic. She was the subject of an urgent referral for psychiatric assessment having taken an overdose of aspirin and she was reported to be angry with her parents (because she alleged they had forced her to have a termination two years earlier). Adult L was re-referred to Psychiatric Services by Adult K because of concerns about her obsessive behaviours and ongoing relationship difficulties in the home. A referral was made by the Psychiatrist for family therapy. Following this referral, which was never pursued, Adult L was asked to leave home by her parents when she was 17 years old because of stealing, drinking and taking drugs.
- 4.2.3 Adult L's adult relationships also proved problematic and she reported difficulties with the fathers of both Child P and Child T. Both of these relationships were relatively short-lived. It is believed that Adult L met Adult F and that he became part of the household. The couple lived in a privately-owned house nearby to Adults K and J. Adult L was employed for a period as a part-time cleaner and Adult F was in full-time employment (believed to be associated with the motor trade). Not a great deal is known about Adult F except that he was the father of a child who lived in a nearby Authority with whom he had regular contact.
- 4.2.4 The impression given by Adult L and Adult F in the course of the S.47 enquiry following Child T's injuries was that their relationship was warm, supportive and problem-free. The reality of the situation was revealed in the Finding of Fact judgement. In this judgement the Judge identified significant difficulties, tension and friction in the relationship which derived largely from Adult L's "trust issues" and which placed considerable pressure on Adult F and the relationship generally.
- 4.2.5 The Judge said in her judgement that the evidence presented throughout the proceedings on Child P revealed a highly dysfunctional family situation. She said that the problems extended beyond the household of Adults L and F to include Adult L's relationship with her parents.

5. Brief Summary of Events

- 5.1 The first possible cause for concern about Child T when he was presented on two consecutive days at Hospital 1 and Hospital 2 with a history of having injured his left leg through trapping it in the bars of his cot. On both occasions he was seen by A&E doctors who did not detect any sign of injury and discharged him home with medication for pain relief. Neither of these presentations was regarded as suspicious by the examining doctors and Child T was not referred for paediatric assessment.
- 5.2 Adult L attended a follow-up appointment at the Trauma Clinic on where Child T was seen by the A&E Consultant. Again Child T was not referred for paediatric assessment and he was discharged home on the same day with no follow-up appointments planned.
- 5.3 The next cause for concern arose when Child T had been provided with a placement for one day per week at a local day nursery to allow his mother to access work experience. On the day in question Nursery Staff were changing Child T's nappy and noted three bruises on his front and four bruises on his back. The matter was reported to the Nursery Manager and it was raised with Adult F (whom they believed to be Child T's father) when he called to collect Child T later that day. Adult F said that the marks had been caused by a piece of wood that had been placed in Child T's cot (to prevent further injuries to his leg) and through "rough and tumble" play with his older sister. The Nursery Manager accepted these explanations, did not consult with any other agency and did not refer to Children's Social Care (CSC).
- 5.4 Child T attended the Nursery in the following week. Once again, while his nappy was being changed staff noticed further bruising to Child T's body (one bruise on his right side and four on his left side between his genitals and his hip.) They also noticed bruises to either side of Child T's forehead.
- 5.5 The Nursery Manager consulted with Child T's Health Visitor and was advised to make a referral to CSC. She did this, having first informed Adult L of her intention to do so (in line with local procedures). There was some delay in the response from CSC and Child T was removed from Nursery by his mother before CSC made contact with the Nursery again. When contact was made, the Nursery Manager provided a detailed account of the causes for concern that had arisen on that day, but did not mention the similar bruising that had been seen the week before.

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- 5.6 Upon receipt of the referral CSC convened a strategy meeting and invited representatives from the local Public Protection Investigation Unit (PPIU). There were no representatives from the Nursery or Health Services present. The outcome of the strategy meeting was to conduct a S.47 enquiry on Child T which was to include a medical examination and a discussion with Child P about the nature of her "rough and tumble" play with her younger brother. There was no consideration of Child P's possible safeguarding needs at this strategy meeting.
- 5.7 Later that day the Social Worker who had been allocated the case (SW1) visited the family home accompanied by two PPIU Officers to make arrangements for Child T to be medically examined at Hospital 1. At this meeting Adult L informed the Social Worker and the PPIU officers of the bruising that had been seen on Child T at the Nursery .
- 5.8 Before the medical examination took place at Hospital 1 SW1 contacted the Nursery and the Manager confirmed the bruising that had been seen on Child T and the explanations that had been offered about their causation.
- 5.9 Child T was examined by a Paediatric Registrar (PR1) who had been made aware of the seven bruises that had been seen on earlier and the explanations that had been offered for these. Upon examination he found bruising to both sides of Child T's head – those on the left side being explained by Adult L as having been caused by Child T bumping his head with his sister and those on the right side caused by Child T repeatedly banging his head on his cot. He also noted bruising to Child T's lower left abdomen and groin which Adult F said was caused by having to hold Child T down and tickling him during the course of changing his nappy.
- 5.10 PR1 accepted that the bruising to Child T's head looked to be accidental but was of the view that tickling alone could not have caused the other bruising. He informed SW1 that the outcome of his examination was inconclusive and it was agreed that Child T could return home to the care of his mother and her partner after the bruises were photographed.
- 5.11 On the basis of the inconclusive medical diagnosis, Greater Manchester Police (GMP) decided to take no further action and it was agreed that SW1 would continue the S.47 enquiry. A letter was received by CSC from PR1 which indicated that, on the basis of the evidence available, the injuries to Child T's groin/abdomen looked like finger prints and were unlikely to be caused by tickling alone. The letter concluded that non-accidental injury could not be ruled out.

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- 5.12 SW1 met with her line manager in a supervision session on a decision was made to convene an initial child protection case conference. SW1 contacted the Safeguarding Children Unit and arranged a conference. On the same day SW1 arranged to visit Adult L to inform her of the conference and to gather information about the family, including details of Child T's father and Child P's father. On the same day SW1 also spoke by telephone to a Paediatric Consultant (CP1) who had reviewed the photographs of Child T's injuries and who was of the opinion that there was no doubt that they were non-accidental.
- 5.13 When SW1 visited the family home later that day Child T was not present. Adult L reported that he was at his maternal grandparents' home. She also told SW1 that she was afraid to do anything with Child T in case he bruised. SW1 did not visit the maternal grandparents' home and did not see Child T on this visit.
- 5.14 Adult F called an ambulance to the family home because of concern about Child T. Adult F had gone to wake Child T and had found him lying face down in his cot, cold and unresponsive. The ambulance conveyed Child T to Hospital 2 where he was found to be dead on arrival.
- 5.15 A preliminary examination was undertaken by the on-call Paediatric Consultant which revealed bruising to Child T's forehead and face which he felt were suggestive of non-accidental injury. Hospital 2 referred the case to Greater Manchester Police and the Sudden Unexpected Death in Childhood (SUDC) Paediatrician was contacted. CSC were informed of Child T's death by GMP who indicated that they regarded the circumstances of his death as suspicious. In the course of this call CSC were informed that Child T had an older sister, Child P, who was at that time staying temporarily with her maternal grandparents.
- 5.16 Later that morning the SUDC Paediatrician examined Child T. The examination was limited due to the presence of rigor mortis but it did reveal bruises to the right side of Child T's forehead and face, bruising to both right and left cheeks and a possible mark to his neck. The examination revealed also that Child T had a torn frenulum. It was known at the time of the examination that Child T had been in his grandfather's care on the day before he died.

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- 5.17 The Duty Manager of the Access and Support Service for CSC (TM2) contacted the PPIU to arrange a strategy meeting to consider any potential risks to Child P following Child T's death. She also suggested that the use of Police Protection Powers might be appropriate. Child P subsequently became the subject of police protection at 2:30pm. The PPIU did not respond to the initial request to attend a strategy meeting and TM2 contacted the Unit later the same day to make a second request. There was no response to this request and instead of a strategy meeting a joint visit was arranged between a Police Officer and a Social Worker to inform Adults K and J of the fact that Child P was the subject of Section 46 powers and to explain to them their responsibilities in ensuring Child P's safety. Child P's placement with her maternal grandparents had been made on the basis of a risk assessment undertaken by the GMP Senior Investigating Officer (DI1).
- 5.18 Child T was the subject of a post mortem examination at Hospital 3 which revealed 23 bruises to his scalp, face and neck, three bruises to the lower half of his abdomen, a torn frenulum, deep (healing) lacerations to both sides of his tongue and evidence of an old, partially healed subdural haemorrhage. The conclusion of the Consultant Forensic Pathologist was that, while the cause of death remained unascertained, there were a number of factors in the case that were strongly suggestive of non-accidental injury.
- 5.19 Following the decision to secure Child P's placement with her grandparents by means of Section 46 powers, arrangements were made for Adult L to have supervised contact at Adults K and J's home. Child P was made the subject of an Emergency Protection Order (EPO) and subsequently she was made the subject of an Interim Care Order (ICO). A home visit was made by CSC Workers to require Adult L and Adult F to find alternative accommodation.
- 5.20 Following the EPO a strategy meeting on Child P attended by CSC, two officers from the PPIU, a representative from Adult Mental Health Services (who were supporting Adult L) and a representative from Local Authority Legal Services. The preliminary findings of the post mortem examination were not shared at this meeting, nor the fact that Child T had been in his grandfather's care on the day before he died, nor that Adult L had said that Adult K was "heavy handed" when looking after Child T.

The conclusion of the strategy meeting was that a S.47 enquiry was to be completed in respect of Child P, that police enquiries were to continue, that Child P was to remain with her grandparents subject to further assessment and monitoring and that CSC would convene a gateway meeting in relation to Child P with a view to an application for an ICO.

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- 5.21 Child P remained in the care of her maternal grandparents and continued to have supervised contact with her mother as well as ongoing contact with her birth father, Adult M. Adults K and J were the subject of a "Friends and Family" assessment and later a court directed risk assessment. There were difficulties throughout the placement in relation to Child P's grandparents working in partnership with CSC and the outcome of the risk assessment was not entirely favourable. This led to CSC drafting a "contract of expectations" regarding future working relations between the family and CSC, Adults K and J's conduct in relation to Adult M, arrangements for Child P to attend pre-school play group, arrangements to promote contact between Child P and her father and the need for strict observation of the requirements attendant on Child P's contact with her mother and Adult F.
- 5.22 Adult K and Adult J signed the "contract of expectations", but did not adhere to it. In the course of making arrangements to increase Child P's contact with her birth father to include staying contact, she revealed that she had been having regular, unsupervised contact with her mother. CSC considered that the risks associated with Child P's grandparents' non-compliance with the "contract of expectations" were too great to manage and a decision was made to terminate her placement. Child P was placed in the care of her birth father.

6. Similarities with Other SCR's and Relevant Research

6.1 This SCR on Child T is the sixth that has been commissioned in Rochdale in the past three years. The earlier cases relate to a 13 year old boy, a 2 year old that was seriously injured by her mother's boyfriend, a child of 3 years who was repeatedly presented at hospital with unexplained injuries, a child of 4 months who was seriously injured by his father and a child of 7 weeks who suffered potentially life-threatening injuries. There are a number of similar issues present in those cases that are evident in Child T's case:

- ◆ The presentations at hospital of a young child with a history of bruising for which no satisfactory accidental explanation was available
- ◆ The failure of the examining doctor to refer Child T for a second (Consultant) opinion in the face of an uncertain diagnosis of NAI
- ◆ The failure of the Hospital to convene a discharge planning meeting
- ◆ The failure to recognise the significance of the risk factors that were evident in the case
- ◆ Poor intra- and inter-agency communication and little evidence of effective inter-agency working
- ◆ Poor standards of record-keeping across all agencies
- ◆ The failure of staff in all agencies to adhere to single and multi-agency procedures
- ◆ Inadequate staff supervision and lack of managerial oversight over practice.

6.2 A number of these issues reflect the findings of the review of SCR evaluations undertaken by Ofsted between April 2007 and March 2008 which appear in the document "Learning lessons, taking action" as well as the Biennial Analysis of SCRs 2001-2003, 2003-2005, 2005-2007. The features that were relevant to this SCR were:

- ◆ poor risk assessment and analysis
- ◆ poor information sharing and inter-agency working
- ◆ evidence of silo practice
- ◆ parent-centred practice and rule of optimism thinking
- ◆ failure of agencies to adhere to single and multi-agency procedures
- ◆ insufficient supervision and lack of management oversight
- ◆ lack of information about unknown men and their role in family life

6.3 In addition to the similarities between Child T's case and other SCR's that have been conducted locally and nationally, there are a number of striking similarities with the findings of the Baby Peter SCR, the Executive Summary of which was published in February 2009. The similarities include:

- ◆ the need for authoritative child protection practice
- ◆ the need to improve inter-agency communication
- ◆ over-reliance on medical evidence to support safeguarding action
- ◆ dangers inherent in placing children with family and friends
- ◆ the lack of rigour and challenge when making inquiries and the willingness to accept adult accounts at face value
- ◆ the importance of quality supervision for staff and the need for effective front-line management and control
- ◆ failure to consider other adults with PR when making alternative placements for children

6.4 Pieces of research which were felt relevant to this Review were:

- ◆ E Munroe (1996)
Avoidable and Unavoidable Mistakes in Child Protection Work
BJSW
- ◆ M Calder (2008)
Contemporary Risk Assessment in Safeguarding Children
Russell House Press
- ◆ Besharov & Douglas (1990)
Recognising Child Abuse
MacMillan Press
- ◆ Stanton Rodgers & Ash (1989)
Child Abuse and Neglect – Recognising and Responding
Open University Press
- ◆ Warner J (2003)
An initial assessment of the extent to which risk factors, frequently identified in research, are taken into account when assessing risk in child protection cases
BJSW
- ◆ Utting W (1997)
People Like Us – the Report on Safeguards for Children Living Away from Home
DoH

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- ◆ Gilbert, Widom, Brown, Fergusson, Webb & Janson (2008)
Burden and consequences of child maltreatment in high income
countries
Lancet

7. Summary and Key Messages

7.1 The Panel was of the view that this case was poorly managed throughout. The Review process has identified poor practice on the part of the key agencies that undertook enquiries into the concerns about possible NAI to Child T. The S.47 enquiry was superficial and lacked rigour and resulted in a flawed formulation of risk which was used to support the decision to allow Child T to return home to Adult L and Adult F's care. This decision exposed Child T to the likelihood of future (escalating) physical harm which resulted in the injuries he sustained in the days before his death.

7.2 The Panel considered the decision by DI1 to place Child P with her maternal grandparents to be injudicious (given the circumstances of Child T's death and the fact that Adult L and Adult F were living in the same household at the time). It appears to have been based on an understanding between like-minded individuals rather than a robust assessment of risk. CSC were clearly unhappy with this arrangement, but took no action to review the placement when they had the power to do so, having obtained a share of parental responsibility for Child P through a successful application for an EPO. There were two further opportunities for CSC to review the placement in the light of emerging concerns about the circumstances of Child T's death (the letter from PR1 and the SUDC professionals meeting), but again no action was taken.

The failure of CSC to exercise proper control over Adult L's contact with Child P at Adult J's home was poor, adult-centred practice and exposed Child P to possible emotional harm. Similarly, the failure to overrule Adult J and Adult L's decision not to accept medical treatment for Child P was poor, adult-centred practice and caused Child P unnecessary suffering. There was further evidence of poor practice when the almost wholly negative outcome of the risk assessment on Adult K and Adult J was ignored and a recommendation was made to the Fostering Panel to approve them as carers for Child P. The "contract of expectations" (which Adult K and Adult J ignored) was an inadequate response to the outcome of the risk assessment.

7.3 It was the view of the Panel, given the events and the escalating levels of violence to which Child T was exposed that there was a degree of predictability about him receiving further injuries (though the extent of those injuries could not have been foretold). Had the significance of the emerging pattern of injury been recognised and appropriate protective action taken, Child T's more serious injuries would have been prevented.

7.4 The process of the Serious Case Review has identified the following key messages:

- ◆ RBSCB should make arrangements to ensure that the decision making process about the need for a SCR complies with the guidance provided in Working Together 2010 (at 7.25).
- ◆ Further work is required on the SCR process, including the need to adequately scope future Reviews to ensure that all those agencies that need to submit IMR's are invited to do so. Also the SCB needs to continue to work with agencies to ensure IMR's are of a 'fit for purpose' standard.
- ◆ The need for all Agencies to afford the SCR process appropriate priority and ensure IMR authors have the necessary relief from their usual duties to allow them to produce timely, "fit for purpose" IMR's.
- ◆ The need for rigour in the S.47 enquiry process. Practitioners need to be skilled in risk assessment, avoid over-reliance on the outcome of medical examination, consider all the risk factors present and ensure that they access and take account of relevant historical information.
- ◆ All practitioners who are involved in enquiries into likely significant harm need to keep an open mind and suspend disbelief about who may be responsible for any harm a child has suffered.
- ◆ All agencies need to retain the child at the centre of practice and avoid parent-centred practice. When CSC have a share of parental responsibility this must be exercised assertively to promote the best interests of the child.
- ◆ When a child who is the subject of safeguarding concerns has to be separated from his/her normal care giver, first consideration must always be given to other adults with a share of PR as a possible alternative placement before making alternative arrangements.
- ◆ All risk assessments should be subject to regular review. All new, relevant information must be taken into account and the level of assessed risk varied accordingly.
- ◆ In order to safeguard and promote the welfare of children it is essential that key agencies have effective working relationships built on mutual trust and respect.
- ◆ Practitioners from all Agencies need to ensure that they have sight of and sign off the record of all minuted meetings they attend.

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- ◆ Practitioners at all levels need access to challenging and supportive supervision to ensure that their work is quality assured. Agencies need to ensure arrangements are in place to exercise adequate managerial oversight and control over the work of practitioners.
 - ◆ Practitioners from all agencies must adhere closely to agreed single and multi-agency policy and procedures. Managers must specifically address this issue in supervision and/or feedback to practitioners.
 - ◆ All services need to develop and maintain "fit for purpose" recording and recordkeeping systems to underpin effective safeguarding practice.

To address these issues the Review Panel agreed the following single and multi-agency recommendations.

8. Recommendations

8.1 Multi-Agency Recommendations

- ◆ SCB make arrangements to ensure that there is careful scoping of any future SCR's and all those agencies that are required to contribute IMR's are identified at the commencement of the review process
- ◆ SCB develop a schedule of competencies for IMR authors and ensure that all agencies select individuals with the necessary experience and skills to provide timely "fit for purpose" IMR's.
- ◆ SCB amend Safeguarding Procedures to require workers undertaking S.47 enquiries to ask examining doctors directly, in the case of inconclusive medical examinations, whether abuse or neglect can be ruled out. If it cannot, enquiries **must** continue.
- ◆ Agencies to instruct staff that all records relating to safeguarding concerns should be timed and dated.
- ◆ SCB make arrangements to discharge its responsibilities for the Child Death Overview Process which comply with the guidance contained in Working Together to Safeguard Children (at 7.25).
- ◆ SCB ensure there is a protocol in place which promotes and supports positive working relationships between CSC and GMP based on mutual respect and trust. The effectiveness of this protocol should be subject to regular monitoring and review.
- ◆ SCB amend multi-agency safeguarding policy to require all children who are awaiting initial case conferences to be seen. The frequency at which they are seen will depend on their needs and circumstances.
- ◆ All Agencies ensure that IMR Authors receive the necessary relief from their normal duties to allow them to produce timely, "fit for purpose" IMR's
- ◆ Staff from all Agencies to ensure they have sight of and sign off the record of all minuted meetings they attend.

8.2 The Nursery

- ◆ Nursery to use RBSCB approved body maps to record injuries/bruises to children.
- ◆ Amend current recording procedures to ensure confidential, fit for purpose records on each child.
- ◆ Report non-attendance to CSC of all children subject of ongoing safeguarding concerns.
- ◆ Improve record keeping to increase knowledge of the child and family's circumstances at the point of admission.
- ◆ All early years settings in the PVI sector are familiar with DCSF statutory guidance and additional guidance on good practice.
- ◆ Early Years settings to be aware of support and advice role of Early Years Advisory Team and child protection designated officers in Sure Start Service in relation to safeguarding issues.
- ◆ Improve recognition of abuse.
- ◆ Improve referral procedures.

8.3 Heywood, Middleton & Rochdale Community Care (GP Services)

- ◆ A significant event proforma has been given to the practice as a basis for a practice meeting and this will be submitted to the child protection unit in due course highlighting changes and incorporating policies covering:
 - (a) Risk markers for significant harm for children
 - (b) Policy for following up children who default clinics
- ◆ Better recording of thoughts and reflections about patient in medical notes which can be shared with colleagues. The learning points arising from this need to be addressed.
- ◆ The intention is that all the GPs will have attended stage 2 child protection training by December 2010.

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- ◆ Work needs to be done regarding the development of better protocols between primary and secondary agencies thus giving guidance to GPs regarding actions to be taken when receiving significant information about injuries to a child. The learning points arising from this need to be addressed.

8.4 Greater Manchester Police

- ◆ To remind all officers to adhere closely to agreed local safeguarding procedures including the need to consider other children who may be in need of protection and whether (depending on the concerns) these children should be medically examined.
- ◆ Remind officers undertaking joint S.47 enquiries of the need to consider all the information available when making risk assessments and not rely wholly on medical opinion.
- ◆ In the course of investigations of child homicides or serious incidents there should be full disclosure of information to CSC to allow consideration of the safeguarding needs of other children unless there is an **overwhelming** reason why this should not happen. In such cases the reason for non-disclosure should be recorded and CSC informed that there is relevant information available that cannot be disclosed.
- ◆ In cases where an Officer from the PPIU cannot be present for the examination of children in the course of S.47 enquiries, that officer should speak directly to the examining doctor by telephone to allow the Officer to clarify the outcome of the examination, interrogate the examining doctor's findings and request a second opinion if necessary.
- ◆ Remind all officers in child homicide or serious incident investigations to adhere closely to the SUDC procedures. As soon as is practicable there should be a separation of the criminal investigation from the enquiries into any other child(ren) affected by the incident. These latter enquiries should be undertaken wholly by officers from the PPIU.
- ◆ To remind officers that during the initial planning of child protection enquiries, the officers and their manager(s) must consider the need for medical examination of all children for whom concerns exist.
- ◆ To include specific guidance in the GMP Safeguarding Policy on the importance of considering the need for medical examination of all children for who concerns exist.

8.5 NHS Heywood, Middleton and Rochdale Community Healthcare (Health Visiting)

- ◆ All cases where a child is known or believed to be the victim of likely significant harm or is in the process of ongoing S.47 enquiry should be referred by the HV to his/her line manager and a decision made about the appropriate level of future supervision.
- ◆ HV's to talk to parents about the presentation of their children at hospital with illness or injury when they receive information about this. Any delay in the receipt of information should not preclude the conversation with parents.
- ◆ HV's to routinely inform single mothers of the issues associated with unknown men having contact with children and seek out information about new men in households.
- ◆ Liaison must take place between Health Visiting Hospital Liaison and the case holding family health visitor when a baby under one year of age presents at hospital. Information about the attendance, its history, whether witnessed, and by whom and who presented the baby at hospital must be shared in a timely manner. Should there be a delay, the receiving health visitor must seek clarification on the cause of admission and not file information if it fails to tell the child's story.
- ◆ Once an injury is noted in a baby under one year, that MAY suggest NAI the case must come to supervision where it can receive the appropriate managerial oversight.
- ◆ Health visitors who are contacted by independent nursery staff must clearly indicate to them when a referral to social care should be made, where there are concerns of significant harm to a child.
- ◆ Development of health specific LAC policies.
- ◆ Discuss with the PCT's (Primary Care Trust) children's commissioner the feasibility of extending bereavement support to children other than those currently receiving a service through palliative/cancer care.
- ◆ Health Visitors must evidence in their records that they discussed injuries to a child with the parent.

8.6 Children's Social Care

- ◆ CSC to ensure that the Managers responsible for decision-making in Access and Support Services have the necessary competencies to undertake this role to an acceptable standard.
- ◆ When CSC share parental responsibility for a child this must be exercised assertively. The desire to maintain working partnerships with parents should not compromise decision-making or action to safeguard and promote the welfare of children.
- ◆ In cases where children have to be separated from parents/carers because of safeguarding concerns, CSC should always consider first all those with a share of PR as an alternative placement before making other arrangements.
- ◆ All children subject to risk assessments should have these reviewed at each supervision session and a record made of any new information available and its impact on the overall analysis of risk.
- ◆ Ensure that the CSC improvement plan's implementation is monitored in addressing the issues raised and incorporate the need for the child to be seen following the decision to proceed to case conference.
- ◆ Review the arrangements for supervision of contact.
- ◆ Ensure contact workers have appropriate skills to manage the contact.
- ◆ Ensure supervision and management decisions are to include review at the point of new/additional safeguarding information to ensure the child's needs remain at the centre of planning.
- ◆ Ensure that RBSCB members revisit the information sharing protocol.
- ◆ Specific training developed between Health, Police and CSC linked to their roles and responsibilities within risk management in S.47 investigations in line with The Children Act 2004 and Working Together 2006.

8.7 Pennine Care NHS Foundation Trust

- ◆ Modify the adult assessment and risk documentation to include triggers re child safeguarding.
- ◆ Improve multi agency communication.
- ◆ Improve the skills and knowledge of front line staff improve assessments with regard to child safeguarding issues and parenting.
- ◆ To ensure all staff follow Trust policies.
- ◆ Agree a recording policy between Children's Social Care and CAMHS.
- ◆ Improve recording within CAMHS.

8.8 Pennine Acute NHS Trust (Medical)

- ◆ The on-call Consultant **must** be informed of all Children referred for medical examination in the course of a S.47 enquiry (Laming Recommendation 76). If the outcome of the examination is that NAI cannot be ruled out or is unclear then the child (if under 3 years old) **must** be seen by the Consultant before discharge. If the child is 3 years old and over the examining doctor **must** discuss his/her findings with the Consultant before discharge and make a contemporaneous record of the consultation.
- ◆ No child who is seen because of safeguarding concerns should be discharged from hospital without a documented plan for his/her future care (Laming Recommendation 71).
- ◆ **Monitoring of vulnerable children under one year of age**
Changes to policy have already been made requiring referral/discussion with Consultant Paediatrician of all children under 1 year of age presenting with head injury, bruising or fracture. Compliance with policy will be the subject of audit.

A means of monitoring vulnerable children by examining cases on the computerised system (Symphony) should be explored and appropriate resources identified.
- ◆ **Consultant input into all referred cases of suspected abuse**
Changes in policy have already been made emphasising the requirement for Consultant input into all referred cases of suspected child abuse. Compliance with policy will be the subject of audit.

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- ◆ **Clear documented evidence of discussions with other agencies**
Improve interagency working by a shared document stating the conclusions and plan of action agreed in writing by doctor and social worker with the aim of ensuring safety of the child/children involved.

8.9 CAFCASS

- ◆ That Cafcass asks Cafcass representatives on LSCB's to circulate information about the existence of significant new child protection procedures in LA areas to affected Cafcass staff.
- ◆ That Cafcass clarify in the contracts with agency staff that it is expected that agency staff will co-operate fully with SCR processes, whether or not they have ceased to be placed with Cafcass by their employing agency.

Signed:

M Muir
Independent Author

Ms C Eastwood
RBSCB Chair

Date: