



SERIOUS CASE REVIEW

EXECUTIVE SUMMARY

CHILDREN: Child T and  
Child N

AUGUST 2007

## 1.0 **INTRODUCTION**

1.1. Rochdale Borough Safeguarding Children Board held a serious case review under Section 8 of 'Working Together to Safeguard Children' following serious injuries to Child T aged 4 months, in October 2006.

1.2 'Working Together to Safeguard Children' (para 8.3) specifies that:  
"The ACPC Overview Report should contain an Executive Summary that will be made public, which includes, as a minimum, information about the review process, key issues arising from the case, and the recommendations which have been made."

1.3 This Executive Summary reflects the information that was available to the agencies involved with Child T and Child N and the Serious Case Review Panel. The Overview Report was completed in August 2007.

## 2.0 **THE REVIEW PROCESS**

2.1 It was agreed that the Review would:

- Receive internal management review reports from individual agencies.

- Cover the period from September 2002 to 29<sup>th</sup> October 2006, and should include Child T , the father , the mother and Child N.
- Appoint an independent Chair.
- Consider the involvement of the family in the review process.
- Include representation from:

Pennine Care NHS Trust

Pennine Acute NHS Trust

PCT (Midwifery and Health Visiting)

G.P. Family Practice

Greater Manchester Police

Pupil Welfare & Inclusion Service

Produce an Overview Report and Executive Summary within stated timescales.

2.2 Contributions have been made by the following agencies:

- Pennine Acute Trust (Midwifery)
- Pennine Acute Trust (Nursing)
- Pennine Acute Trust (Medical)
- Heywood Middleton and Rochdale PCT
- Greater Manchester Police
- G.P.
- Pennine Care NHS Trust
- Pupil Welfare & Inclusion Service.

3.0 **SUMMARY OF EVENTS**

3.1 Child T was born on 10<sup>th</sup> June 2006. He is the second child of the mother and has a half-sibling, Child N.

His father is said not to be the father of Child N.

3.2 Both Child N and then Child T had had excessive presentations to medical services with illnesses and injuries almost from birth. The injuries were largely unexplained.

3.3 Their mother, had presented to a number of professionals with issues of low mood and threats of self harm.

3.4 The father of Child T had expressed to a counsellor his concern that he may harm himself or another, and that he required help to control himself. Several stresses were identified within the family, including “fighting with his partner.”

3.5 On 29<sup>th</sup> October 2006 Child T was admitted to hospital with a suspected fracture of his leg. A full examination revealed a total of six fractures to

left and right fibia, tibia and ankles, of different ages.

3.6 A Police investigation resulted in an admission from the child's father that he caused the most recent injury accidentally.

#### 4.0 **KEY ISSUES ARISING FROM THE CASE**

4.1 The key issues to emerge from the Case Review were as follows:

- Failure of agencies to recognise the need to safeguard the welfare of children, despite two young children receiving regular marks and bruises, the majority of which were unexplained.
- Failure of professionals to recognise possible indicators of abuse to children.
- Failure by professionals to understand the well research correlation between family violence and risk of abuse to children in the household.
- Failure of communication between professionals and between agencies.
- The adequacy of record keeping practices.
- The adequacy of paperwork and systems to highlight those children who may need to be safeguarded.

## 5.0 **RECOMMENDATIONS**

5.1 The Serious Case Review Panel makes the following recommendations to the Rochdale Borough Safeguarding Children Board and its constituent agencies:

### **All Agencies should:**

1. Ensure that staff have regard to their duties under Section 11 of the Children Act 2004 which refers to the need to make sure their functions are discharged with a focus on safeguarding and promoting the welfare of children.
2. Ensure that protocols for recording include the need for detail, accuracy and clarity when recording observations of and histories of injuries to children. Protocols should make the use of skin maps as a mandatory part of recording.
3. Ensure that the issue of ownership of records is addressed, and clear protocols published when joint services are set up.
4. Ensure that staff follow up and record the outcome of referrals made to other agencies.

### **Pennine Acute Hospital NHS Trust should:**

1. Review the amalgamation of hospital records with a view to ensuring the maximum contextual information is available to assist staff in decision making.  
*(The Panel is aware that this issue has been referred to the Trusts Records Group for consideration.)*
2. Review the content of thresholds for the use of the 'Cause for Concern' form, in order that the form directs users to focus on issues of risk.
3. Ensure that medical staff coming into contact with children and young people receive specialist training around the recognition and diagnosis of non-accidental injuries, and causes for concern and suspicion.
4. Ensure that other staff in the Trust meet their statutory requirements with regard to Section 11 of the Children Act 2004, ie, that they should have an understanding of their role and responsibilities and those of others, and be enabled to participate in training both single and multi-agency.
5. Develop a protocol for use when children under the age of 2 years present with injury, which involves the need to consult with senior colleagues in their own or other agencies and ensure staff are trained in its use.
6. Develop a system that ensures that the information regarding any

child seen under the age of 2 years with injuries is referred to the Health Visiting Service by telephone within 24 hours.

7. Introduce guidelines and a pathway for the management of post-natal depression in the Midwifery service

*(The Panel is aware that a pilot scheme is in place at the present time.)*

8. Ensure that the details of the transfer of care of a mother and baby from the Community Midwifery Service to the Health Visiting Service is documented in the midwifery records.
9. Ensure that referrals made to the specialist midwife are made in writing and a copy retained in midwifery records.

**Middleton, Heywood & Rochdale PCT should :**

1. Ensure that any family in which bruising is presented on immobile babies is brought to the supervision arena for discussion with senior staff, thus assisting the analysis of written factual information.
2. Continue to pursue the need for a system that allows Health Visiting staff to have a direct referral process to Paediatrician when causes for concern arise regarding safeguarding concerns to young children.
3. Ensure that liaison between family Health Visitors and Health Visitors who have contact with families in clinics, is documented in the Health Visiting notes.

4. Explore means to ensure that information received by G.P. Practices where concerns exist is communicated to the appropriate staff in a timely way and disseminated to colleagues in other agencies.
5. Explore how 'significant event' reporting could be promoted within G.P. Practices to discuss families where safeguarding concerns exist.
6. Develop a means to ensure that when receiving information about concerns within a family with children, the information is correlated with historical information to give staff a complete picture of the situation.
7. Ensure that GP's attend training in order that they can understand their role and responsibilities in respect of safeguarding and promoting children's welfare in the multi-agency arena.
8. Set up a system of quality assurance within GP practices to measure responses to and outcomes of safeguarding issues, which come to the attention of the practice.
9. Develop a protocol for onward referral from the Walk-In Centre.

**Pennine Care NHS Trust should:**

1. Ensure that counselling staff receive further training about linking the risk of adult anger and violence to risk to children in the family,

and the action which should then be taken.

2. Clarify who owns the notes in the Oldham Counselling Service, as well as in other Pennine Care jointly delivered services within the community, and establish appropriate record keeping, and release of notes procedures.
3. Make all Management and Information Governance staff in Pennine Care aware of the processes in the Child Protection Policy re Serious Case Reviews, why notes are being requested, and the purpose of management reviews.

**Rochdale Safeguarding Children Board should:**

1. Assist individuals and agencies to make safeguarding decisions by providing information on identifying potential abuse, both in training and in written guidance.
2. Disseminate the issues and recommendations from this Serious Case Review Report to Oldham Safeguarding Children Board.

6.0 **IMPLEMENTATION OF RECOMMENDATIONS**

- 6.1 The Serious Case Review Panel expects that each Agency will ensure that their recommendations are actioned and implemented.
- 6.2 Progress in implementing the recommendations should be regularly

monitored by the Local Safeguarding Children's Board.

**CHAIR.**

14<sup>TH</sup> September 2007.