



EXECUTIVE SUMMARY

SERIOUS CASE REVIEW OVERVIEW PANEL

REGARDING :

**Child Y**

**HELD UNDER PART 8 OF**

**'WORKING TOGETHER TO SAFEGUARD CHILDREN (2006)'**

**SEPTEMBER 2006 - MARCH 2007**

## **1.0 FOREWORD**

- 1.1 Rochdale Safeguarding Children's Board held a Serious Case Review under Section 8 of *Working Together to Safeguard Children (2006)* following a serious injury to CHILD Y in June 2006. The Overview Report was completed in March 2007.
- 1.2 *Working Together to Safeguard Children (2006)* (para 8:33) specifies that:  
'The Local Safeguarding Children's Board overview report should contain an executive summary that will be made public and that includes, as a minimum, information about the review process, key issues arising from the case and the recommendations which have been made.'
- 1.3 On 25<sup>th</sup> June 2006, CHILD Y was brought to the Accident & Emergency Department of Rochdale Infirmary by ambulance. CHILD Y had inter-cranial bleeding and his injuries resulted in brain injury and permanent disability.
- 1.4 CHILD Y's birth father was charged with and subsequently found guilty of a Section 18 Assault against the child.
- 1.5 The Executive Summary reflects the information that was available to the Serious Case Review Overview Panel and the conclusions that were formed when the Overview Report was completed in March 2007.

## **2.0 THE REVIEW PROCESS**

2.1 Rochdale Local Safeguarding Children's Board commissioned an Overview Report in September 2006.

2.2 The Serious Case Review Panel which considered the available information and produced the report in respect of CHILD Y and his family included representatives from:

Pennine Acute NHS Trust

Pennine Care NHS Trust

PCT (Health Visiting)

Family GP

Manchester Mental Health Social Care Trust

Local Authority Social Care

Local Authority Learners & Young People Services

Greater Manchester Police

The Chair of the Panel was independent of all the agencies and professionals involved.

2.3 Each Agency that had had contact with CHILD Y and his family submitted individual management reports of their involvement with the child and family.

2.4 The Overview Report brought together and analysed the findings of the various reports and made recommendations for future action to the Rochdale Safeguarding Children's Board.

2.5 The Overview Report was completed in March 2007.

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

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

- Sharing of information and communication between professionals and between agencies, both written and verbal.
- The need for clarity about each agency's role and responsibilities.
- The difficulties of cross boundary working when children and family members are involved with professionals in different geographical areas.
- The need for the tightening up of Acute Trust procedures around discharge planning.
- The inadequacy of record keeping practices.

## **4.0 RECOMMENDATIONS**

4.1 The Rochdale Safeguarding Children's Board and its constituent agencies should ensure that:

1. Groups of professional staff highlighted in the review who are not able to access training around childcare issues, should be targeted as a priority for single or multi-agency training.
2. Training for staff within constituent agencies highlights the importance of issues of communication, liaison and information sharing between professionals and includes information about agency roles and responsibilities.
3. That agencies review their protocols around information sharing, particularly where cross boundary issues exist for service users and that the relevant Boards and Strategic Networks are made aware of the difficulties and take the lead on finding a resolution.
4. That each agency reviews and amends their policies around recording to include guidance that when a cause for concern arises with regard to a child or young person under 18, factual information about the nature of that concern should be documented and responsible staff should ensure that the appropriate action is taken to follow up the stated concern.
5. That the guidance with regard to discharge planning meetings drafted by the Pennine Acute Hospitals Trust is adopted and actively promoted within the trust.

6. That all staff involved in the discharge of children and young people receive appropriate training linked to the Knowledge and Skills Framework.
7. That consideration is given by the Acute Trust as to how discharge planning is improved. One example may be the creation of a Discharge Co-ordinator as currently exists for adult patients in the Trust.
8. That referrals to other agencies are documented, and outcomes of referrals monitored and recorded.
9. That consideration is given at the appropriate level for the development of protocols within Children's Centres for the sharing of files and information to encourage and underpin a more integrated service.
10. That the recommendations of this review are shared with the Local Safeguarding Children Boards responsible for the areas covered in the case review.

## **5.0 IMPLEMENTATION OF RECOMMENDATIONS**

- 5.1 Rochdale Safeguarding Children's Board prepared an action plan based on the recommendations of the Overview Report. Progress in implementing the

recommendations will be regularly monitored by the Safeguarding Children's Board.