Derbyshire
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Board

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SERIOUS CASE REVIEW

DERBYSHIRE SAFEGUARDING CHILDREN BOARD

Child H

EXECUTIVE SUMMARY

June 2009

In order to preserve anonymity substitute initials have been used in this summary

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1. Agencies Involved

- Derbyshire Police
- Derbyshire Children and Younger Adults Department
- Derbyshire County Primary Care Trust
- Derbyshire Probation Service
- Nottingham University Hospitals NHS Trust - Queen's Medical Centre (QMC)

This executive summary has been produced following the resubmission of the serious case review. This report reflects the discussions and conclusions of the resubmitted review

2 Membership of the Re-submission Panel

Rachel Dickinson Strategic Director Leicester City Council (Independent Chair) (formerly of Derby City Council)

Ian Johnson, Assistant Director, Derbyshire County Council

Jane Parfrement, Deputy Assistant Director, Derbyshire County Council

Rachel Walker, Detective Inspector, Derbyshire Police

Dona Womack, Strategy Officer, Derbyshire Safeguarding Children Board

Kathy Webster, Consultant / Designated Nurse, Safeguarding Children

Patricia Field, Consultant Paediatrician/ Designated Doctor

Miles Dent, Safeguarding Children Manager

Sandra Marjoram , Senior Manager, Derbyshire Probation Service

3 Reason for the Report

This is the Executive Summary of a Serious Case Overview Report as required under Chapter 8 of Working Together to Safeguarding Children (HMSO 2006) and commissioned by Derbyshire Safeguarding Children Board. It follows the serious injury of child H aged 2 on 1 January 2008.

This report is based upon information provided by the various agencies involved in providing services to H and her family, on discussion within the SCR panel meetings and on relevant background material for agency policy and practice guidance.

The conclusions and recommendations are based on analysis of the information provided, and from available research papers. They are intended to assist in the application of 'best practice' in the future for all agencies.

In order to preserve anonymity substitute initials have been used to refer to individual family members mentioned in this summary.

4 Purpose of the Serious Case Review

As stated in Chapter 8 of Working Together to Safeguard Children (HMSO 2006) a Serious Case Review is required when a child dies and abuse or neglect is known or suspected to be a factor on that child's death. The objectives of a Serious Case Review are to:

- Establish whether there are lessons to be learnt from the case about the way in which local professionals and organisations work together to safeguard and promote the welfare of children
- Identify clearly what those lessons are, how they will be acted on. And what is expected to change as a result.
- As a consequence, improve inter agency working and better promote and safeguard the welfare of children.

This report examines the actions of the agencies involved with H and all her family members. It considers individual agency policies, procedures and decision making and looks at how the agencies interacted and communicated with each other. The recommendations reflect the lessons to be learnt and are intended to improve services for other children and their families in the future.

This report also takes into account the views of H's mother and maternal grandparents who were interviewed as part of the Serious Case Review.

5 Summary of the Case and Background to the Report

Child H was a healthy, lively, outgoing two year old when she presented in September 2007 at hospital with fractures to her left leg and wrist and with bruising to her chest. The doctors made a referral to Social Care.

H lived with her mother, her mother's partner (stepfather), her three-year-old brother and baby half sister. Stepfather's three year old child was also present in the household at the time of the injury. The family were not known to Social Care; although the maternal grand-parents who lived close by, were well-respected and experienced carers within the local community and were known to service providers.

At a strategy meeting it was acknowledged that two fractures, with no clear history of an incident, indicated a strong possibility of non-accidental injury. Immediate arrangements were made for H's mother and stepfather to be supervised at all times whilst caring for the children. H's maternal grandmother agreed to provide the supervision and moved to live in the children's family home. This put considerable strain on the grandparents' own domestic arrangements.

At the initial case conference it was agreed that H and her siblings each needed a child protection plan. Stepfather's child who had been staying with the family was not formally considered at this, or any other meeting.

It was stipulated in the protection plan that there should be continuous supervision of both adults whilst they were with the children. However it soon became apparent that all the adults regarded this as disruptive and intrusive to family life and, as a result of ongoing pressure applied by family members, supervision was quickly reduced to periods seen as presenting the greatest stress, such as meal times and bedtimes. Family members objected but were viewed as co-operative with the supervision arrangements as well as with the Core Assessment and Family Assessment sessions carried out by Social Care staff.

The assessments undertaken by Social Care and the reports from other agencies to the case conference and the core group meetings all gave a positive view of the quality of care given to the children and the family functioning. However the assessments had not been fully completed in time for the review case conference.

At the initial strategy meeting it was reported that Stepfather had a history of two convictions for violent offences. His ex partner had said that he could be aggressive when drinking. Stepfather was asked about this and said he had grown up and changed. This view was not challenged or explored in any way. Neither H's mother nor grandparents were asked about any violence in the relationship and they did not disclose any concerns.

Because of the grandparents' role in caring for other children the family was known to different sets of workers from social care. The level of formal information sharing between those workers was ineffective and the needs of the different sets of children were prioritised by different workers. Good information sharing practice is critical to keeping children safe, it was not uniformly apparent in this case.

The practitioners involved with this family were over optimistic about the capacity of the adults to prioritise the needs of the children. The apparent co-operation in managing the supervision and the positive responses in the assessment process allowed workers to believe that the children were safe and that, in the absence of a definitive diagnosis of the injuries, there must be an innocent explanation for the fractures. They ceased to consider the bruising to the chest. Histories were not properly taken and inconsistencies were not challenged. By the time of the review child protection conference there was minimal supervision of the children, their mother had taken a job which involved her being away from home overnight and the assumption had been made that the children were safe.

At the review case conference in December 2007 the issue over whether H's fractures were accidental or non-accidental was still not resolved. The medical reports were confusing and there was no paediatrician at the conference to interpret or discuss them. The conference concluded, erroneously, that the doctors believed that the fractures were most likely to be accidental. The Core Assessment was incomplete and had not recorded information about H's mother or Stepfather's family and social background. The family assessment, and in particular H's stepfather's contribution, had six sessions still to run. In spite of this it was agreed to remove the children from the child protection register and discharge the protection

plan. All the reports to the case conference were positive and the family agreed to work with Social Care to complete the assessments under Child In Need arrangements. The conference members were reassured that H's grandparents were closely involved with the family, and offering support. The assumptions were not challenged by anyone at the conference.

The case conference, which was chaired by a locum chair-person, did not have all the information necessary to make the decision that H and her siblings no longer needed a protection plan and this decision should not have been made.

Ten days later H was seriously sexually assaulted whilst staying at her mother's place of work. The incident happened in the night, whilst the children were in the care of Stepfather; he had been drinking heavily.

H's medical assessment and treatment were timely and appropriate but there was seven hours delay before the police received a formal referral of a section 47 investigation. Critical forensic evidence may have been lost.

H's stepfather was convicted of unlawfully wounding and sexually assaulting her; there was insufficient evidence to convict him of rape. He will serve a minimum of eighty-nine months in jail before being considered for parole.

None of the information known by child protection professionals or by the family at that time would have led to the prediction that Stepfather might commit a violent sexual attack.

However, if information had been shared and all parties had been aware of Stepfather past history, his jealous behaviour and his tendency to aggression with drink, and had been able to discuss these openly and fully, the professionals and the family could have put in place a robust protection plan. It is unlikely that Stepfather would have been allowed sole care of the children overnight, given his pattern of drinking.

6 Issues for Agencies and Lessons Learnt

All

Inappropriate deregistration at the review case conference

The multi-agency conference members were not in a position to make the decision because the assessments were incomplete and there was no doctor present to interpret the medical reports. The knowledge that two separate fractures and un-associated bruising, with no clear explanation, were most likely to be non accidental in nature was lost. Members of the core group had developed a very positive view of the family and wanted to believe that there was an innocent explanation for the injuries to H.

The dangers of over optimism

The rule of optimism allows workers to ignore evidence in cases where the family is seen as competent and co-operative. Munro (19960 suggests that in cases of injuries that called into question an otherwise positive picture “ the injuries seem simply to disappear from people’s awareness”

Health

Formal referral to initiate a Section 47 investigation

A junior doctor who suspects child abuse should make a referral to Social Care after checking with a senior colleague. If the first person that suspects the diagnosis fails to make the referral, others might not remedy the omission on the grounds that they believe the referral has already been made. This is particularly important where doctors work shifts.

Written communication and documentation

The importance of documenting formal referral to Social Care and of the discussions and decisions involving other agencies has been highlighted in this review.

Clarity of paediatric medical opinion

Giving a medical opinion over likely causation is always difficult. Comment can only be made on the basis of “probability of NAI”, rather than “definite NAI”. The stakes for giving too much emphasis to one mechanism or the other can be high. Phrasing of opinion is not standardised and, as in this case, can be confusing and misinterpreted. Guidance on report writing for doctors in cases of child protection has been requested from the Royal College of Paediatrics and Child Health child protection special interest group. It is important that child protection reports should be subject to supervision and peer review.

Follow up

Advice to the multi agency core group by the paediatrician involved in diagnosis of possible non-accidental fractures remained an important aspect of management, even after the child has been discharged from medical follow up. There should be clear arrangements to ensure that this ongoing paediatric advice is available and accessible.

Paediatric presence at case conferences

The paediatrician was not specifically invited to the review case conference. If contact had been made with the paediatrician responsible for ongoing advice she would have been aware of the importance of attending to interpret the medical reports.

Police and Social Care

- When a social worker or police officer receives a message that a very young child is in hospital with a genital injury they should make direct contact with the doctor involved to enquire about the possibility of sexual abuse.

Social Care

Supervision
The importance of regular good quality, recorded supervision for Social Workers and front line managers undertaking child protection work cannot be underestimated. It provides the opportunity for reflection, challenge and support which cannot be substituted by informal discussions in team spaces. Its absence in this case for two of the key professionals almost certainly impacted on the outcome for these children.

Timely referral when there are child protection concerns
Social workers should not delay their decision to make a referral to the police when there is information to suggest that a child may have been abused. In this instance a delay in referral had direct impact on the ability of the police to secure an area that may have been regarded as a crime scene and valuable evidence was lost

Safeguarding the Needs of All Children Including Those Not Resident in the Household

The review of this case highlights the importance of evidencing the safeguarding needs for all children of the family including those who are not resident full time in the household within appropriate case files. The ICS system requires an individual case record for each child of the family.

The Involvement of Senior Managers in Mediating Between the Issues for Different Children
The need to mediate the needs of the different children could have been addressed by the involvement of the district manager to facilitate exchange of information, and to balance conflicting views of the family

Assessments
This review has highlighted the importance of undertaking assessments before making key decisions and ensuring that they are thoroughly and objectively completed. There were issues in relation to timing and completion of core assessments which impacted on the available evidence for conference. Because of the overly optimistic view of the family, even if assessments had been completed, it is likely they would have given an unrealistically positive view of the family. This highlights the importance and significance of gathering information about the history, experiences and behaviour of care givers and the use of critical challenge and analysis to test out the information and evidence presented during the assessment.