Learning Summary SILR12A

Introduction

This is a summary of a Serious Incident Learning Review (SILR) which was undertaken to review the practice and inter-agency work carried out and identify any lessons learned to inform future practice. The child sustained non-accidental injuries which resulted in permanent impairment, both physical and developmental. The circumstances of the case were discussed at the Serious Case Review Sub Committee on 24/02/2012 and the decision was made to hold a SILR.

Review Process

The Chair and Independent Author were commissioned to undertake the Review; she was not employed by any agency involved with the case and had no knowledge of the case previously. A number of agencies were identified as having contact with the case and had involvement in the review:

- Derbyshire Social Care
- Children's Centre
- Derbyshire Constabulary
- Derbyshire Probation Service
- Nottingham Constabulary
- Health Visiting Services
- Midwifery Services
- GP Practices x 2
- Nottinghamshire Health Service
- EMAS
- Derbyshire Healthcare NHS Foundation Trust
- Chesterfield Royal Hospital
- Sheffield Children's Hospital
- NHS Direct.

The child's parents were informed that a Learning Review would take place and the child's mother was seen as part of the review process.

The agencies involved provided a chronology and a summary report for the review. The reports informed the two challenge meetings which highlighted a range of issues and lessons to inform future practice.

Family Background

The child's father was viewed as a violent man who used alcohol and did not cooperate or seem open and honest with professionals. There was evidence to suggest that he had abused a child from a previous relationship. The child was permanently removed from their care and there was a finding of fact in Care Proceedings which found that the injuries had been sustained in the care of both parents.

There was little known about the mother's history although it was known that she had a concealed pregnancy resulting in a miscarriage in 2006. It was believed that the parent's relationship began in 2007. An incident of domestic violence was reported in 2009, the mother was pregnant at the time. In 2011 the father received a Community Order following a conviction of Battery against the child's mother. The incident was not referred to children's social care by the police but a referral was later made by the probation service. Children's Social Care was aware a previous child had been removed but did not undertake an assessment. Checks were made with the health visitor and a home visit was requested although the information regarding the background was not passed onto the health visitor. Later that year the mother sought help and support from the children's centre.

Circumstances which led to the Review

The child was born in October 2011 and was diagnosed with renal problems. A series of appointments were attended. At an appointment in January 2012 the child was said to have been unwell the previous week and appeared pale but otherwise well. Probation records indicate that mother, child and sibling had moved to new accommodation in December 2011. Father was reported to be not living at the property although was present during a visit by the health visitor. The health visitor undertook a 6 week review in December 2011 and noted the child's head circumference had increased and had crossed the centile chart from 91st to the 99.6th. This had been on the 50th centile at birth. The health visitor asked the mother to inform the GP however the child was not then registered with a GP. The child was not taken to see a GP until the end of the month.

The following day the police were called to a domestic violence incident. Mother retracted her complaint and a DASH risk assessment was completed although it was not passed to the Police Central Referral Unit and so a referral to Children's Social Care was not made.

In early January 2012 the child was seen by an Out of Hours GP and was described as being unwell. A thorough examination was taken. The child was found to be well and there were no suspicions of non-accidental injury. The child was seen again on two further occasions by a GP, there were no concerns about non-accidental injury

but the GP discussed the child with a Paediatrician and referred him to the Rapid Access Centre at a hospital in the City for follow up. He was seen on the 31st of January 2012 due to a large head circumference. There was no concern about non-accidental injury during the appointment; the situation was to be reviewed following the outcome of a scan. Later that same day the child was taken to a hospital in the County and later transferred to a Children's Hospital due to the severity of his injuries. The child was treated in the Intensive therapy Unit due to his collapse and the severity of his injuries which have resulted in permanent damage and disabilities.

Analysis and Learning

Some agencies held information regarding the father's history and the risk he may pose to partners and children. Historical information was not obtained and did not inform the assessment and work carried out by a number of agencies, including Children's Social Care, the Children's Centre and the Police. The Police were aware of domestic violence incidents and did attend however referrals were not made to Children's Social Care. A referral was made by the Probation Service but this did not result in an assessment.

Father was elusive, if not dishonest about where he was living. It is not clear at the extent of enquires made by agencies to confirm where he was residing.

There were two occasions when the child protection procedures were not adhered to and resulted in a failure to act. Children's Social Care did not follow up appropriately the referral made by Probation and the Police did not trigger a referral to Children's Social Care following a domestic abuse incident.

The threshold was also met to refer the Mother to MARAC. This would have assisted in identifying the level of risk that Mother was experiencing.

The child's head circumference had increased greatly around mid-December. Mother was advised to contact her GP but registration was delayed which resulted in the child not being seen by a GP until the end of December. The Health Visitor had agreed to follow up the child head circumference in 4 weeks however when she saw the child 4 weeks later the child's head circumference was not measured.

The child was seen at the City Hospital on 25.01.2012 at the Renal Clinic, he was advised to see the GP regarding his head circumference. The child was seen by the GP 2 days later, a referral was made back to the City Hospital. He was seen on 31.01.2013 and referred for an urgent MRI Scan. Later the same day he was taken to the County Hospital following serious non-accidental injuries. The subsequent investigation in relation to the child's injuries was properly managed in accordance with the Derby and Derbyshire Safeguarding Children Procedures.

The finding of fact in Care Proceedings found the injuries had been caused by shaking episodes on 20.01.2012 and 31.01.2012.

Conclusions

The review had identified a range of issues which have contributed to the failure to safeguard the child. These relate to the failure to locate and take into account the previous information held about the child's father. There had also been a failure to make referrals and respond appropriately to referrals. There is a general issue of not asking questions about Father's residence, and linking incidents of domestic abuse when offenders move to different households. There have been a number of communication issues which have emerged, affecting all agencies involved within the review.

There has also been evidence of good practice in particular the actions of all medical staff who responded to the incident on 31.01.2012. The response by the out of hours GP on 10.01.2012 was timely, thorough and properly considered the social situation. The action of the GP in terms of discussion and prompt referral to the Rapid Access Clinic at the City Hospital and the subsequent staff involved with the Section 47 enquiries were appropriate and of a high standard.

In conclusion the abuse experienced by the child was preventable, if the history of the father had been considered it is likely the child and his sibling would have been safeguarded. It was also predictable that given the history that Father almost certainly had harmed a child in the past it was an indication he could abuse a child in the future.

Recommendations

- Where it is identified that any individuals has harmed a child as a conclusion of S47 enquiries, Care Proceedings or Criminal Proceedings, arrangements should be put in place to ensure that records are appropriately flagged in order that they are available in relation to their future contact with children. Full names and aliases should be recorded. **DCC CAYA**

- Steps should be put in place to ensure that concerns for children where domestic violence is a feature are responded to in an appropriate and thorough way, taking into account all historic information. Where there are children under 5 years of age, or there is a pregnant woman, Initial Assessments should be considered where checks reveal concerns. **DCC CAYA**

- Full background checks should be made in all cases where concerns are expressed about a child. These checks should include GP, other health professionals, Police and Probation and schools where this is relevant. **DCC CAYA**

- Children's Centre staff should also complete full background checks and ensure that liaison with other professionals takes place as required. **DCC CAYA**

- Where Social Care request input from another agency, they should be clear about why the request is being made and what action is required in terms of feedback. Cases should not be closed until the feedback is received. **DCC CAYA**

- Where information comes to light that an under 16 year old is pregnant, appropriate enquiries should be made to determine the circumstances of the pregnancy, involving the Police if it is considered that abuse has occurred. The safeguarding procedures should be followed. **DCC CAYA**

- The newly implemented policy regarding routine enquiries about fathers, partners and other relevant information should be subject to audit and included in training programmes. **Health Visiting Services**

- Where health visitors are asked to undertake visits to families due to concerns, they should establish exactly what the concern is and what action is required, including feedback. **Health Visiting Services**

- Health Visitors should always make enquiries about domestic violence, If necessary finding a private environment to do so. **Health Visiting Services**

- During antenatal care and childbirth, the names and status of those attending with the mother should be recorded at all times. **Midwifery Services**

- Opportunities should always be found to make enquiries about domestic violence with pregnant women in a private environment. **Midwifery Services**

- Where children are seen in any secondary health setting, information about their care should be copied to health visitors as well as GP's. (see also LSCB recommendation) The issue of delay in clinic letters being sent should also be addressed. **Secondary Health Settings**

- Checks should be in place to ensure that the current DASH system is failsafe. **Police**

- All Police Officers attending domestic violence calls should make enquiries about whether children are present and make links with other agencies as required by the protocol. **Police**

- Where reports are received in relation to an adult patient where a child has been removed due to safeguarding concerns and a risk is identified for any future children, these should be flagged on the relevant systems and should be accessible to key staff within the practice. **GPs**

- A protocol should be put in place in relation to Learning Reviews to ensure that there is robust and timely information sharing with all agencies and that there is full engagement where reviews occur. This is particularly relevant to GPs. **DSCB**

- LSCB training should specifically address the issue of critical questioning by all professionals, both in relation to communication between agencies and with families. **DSCB**

- The Chair of the LSCB should communicate with neighbouring LSCBs with regard to hospital information being sent to health visitors. This has been addressed with QMC but there is a wider issue across other boundaries. **DSCB**

- Consideration should be given to making national representation regarding disclosure of information on domestic violence and other safeguarding issues to new partners where agencies have had previous concerns. **DSCB**

- The LSCB should develop systems whereby the links between domestic violence and child abuse can be made. This should be incorporated into staff training, publicity campaigns and practice with individual families. **DSCB**

- The LSCB should ensure that all agencies have robust systems in place to flag adults who pose a risk to children and that this information is accessible to all relevant staff. **DSCB**