



**LEICESTERSHIRE AND RUTLAND LOCAL  
SAFEGUARDING CHILDREN BOARD**

**SERIOUS CASE REVIEW**

**EXECUTIVE SUMMARY IN RESPECT OF:  
CHILD Y**

**JULY 2009**

**24.07.09 (Amended October 2010).**

## **1 Introduction**

This is a summary of a Serious Case Review (SCR) that was established to consider the circumstances leading to the serious injury of Child Y in late 2008.

The child had, according to evidence available when presented to an Accident and Emergency Department, suffered a potentially life threatening injury as a result of abuse and, therefore, in accordance with Working Together to Safeguard Children, 2006, paragraph 8.2 it was agreed that a Serious Case Review would be undertaken in order to examine inter-agency practice and information sharing and learn any lessons.

The Executive Summary provides information on:

- The Serious Case Review process
- The circumstances of the child and the family
- Lessons learned

and

- Recommendations for action by the four Safeguarding Boards who had some contact with the family.

The findings of the Review have been reported in detail to the Office for Standards in Education (Ofsted) as is required. The Review took longer to complete than the standard expected because it had to co-ordinate information from agencies in four local authorities.

### **Family background**

Child Y is a white British child with no evidence of any different cultural or heritage needs and no specific religion. This is the child of young parents who have a pattern of behaviour which indicated a number of reasons that could prevent them being able to care safely for Child Y. However, a pre-birth assessment, completed by a social worker, concluded that there was sufficient family support for his parents to care adequately. Following the birth this child had two periods in hospital which allowed close observation of the level of parental care. While the mother has been described as having a learning difficulty there is no evidence that she did not understand the expectations of ensuring a safe pregnancy and birth, or that her minor disability had any impact on her ability to care for herself or her child.

Although Child Y was injured in Leicestershire this child only lived in the county for a few days and was not known to this local authority prior to the injuries occurring, or to any agency within Leicestershire County.

## **Serious Case Review process**

The SCR considered whether any of the agencies involved had knowledge that, if acted on differently, could have prevented the incident. The Review has identified some lessons to be learned and has recommended some improvement to professional and inter-agency practice to improve the way different agencies work together in future, to safeguard children and young people.

The Review was carried out in line with government guidance and has been co-ordinated and hosted by the Leicestershire and Rutland Local Safeguarding Children Board (LSCB) on behalf of the other authorities that were directly involved in providing services to the family, namely Staffordshire, Birmingham and Derbyshire. LSCBs are committed to learning lessons from this Review to develop and improve how children are safeguarded through the work of professionals and agencies, and the way in which they work together.

Each agency involved with the family including those only involved after the injuries occurred, was asked to do a review, called an Individual Management Review. The Reviewer had to be someone who had not worked directly with the family or been the line manager of any worker who had been involved. The Reviewers read all the records relating to the family and spoke to some of the workers and their managers. The Reviewers' responsibility was to be thorough, objective and critical in order to identify practice which did not meet the required standards as well as any good practice. It was also important to understand why certain actions were taken and decisions made. The Reviewer then produced a chronology, what happened and when, of the agency's involvement and wrote a report of their findings.

The Serious Case Review Group, made up of representatives of the four LSCBs and the agencies who wrote Individual Management Reviews, considered all the reviews and analysed the professional practice and the way in which the agencies worked together. The LSCB arranged for an Independent person to Chair the panel and the report to be written by an independent person, the Overview Author, who was not employed by any of the agencies. Her responsibility was to look critically at the Reviews and work with the group to draw conclusions from the information and analysis and then to write an Overview Report.

The family were advised at the beginning of the review that a decision had been made to undertake a Serious Case Review. The review was explained to them by letter, incorporating a leaflet for families which gave further information. Assurances were given to family members that their views and opinions would be sought when other investigations had been completed. Further contact was made at the conclusion of the investigation and the views of family members sought.

### **3 Key Issues**

The records from all agencies indicate that there was sound professional practice with family members until 2008, just before the birth of Child Y.

However, before and following the child's birth there were two key areas of practice when different decisions could have been made about the child's care and supervision. The first focuses on assessment and management oversight in Staffordshire Children's Services and the second on the 'start again' response in NHS agencies (hospitals and community services).

The social work and NHS agencies in Staffordshire did not make use of historical information on the family setting, including some key risk factors for the care of a young child. There was a reliance on self reporting and an assumption of competent caring without a balance of risk against protective factors. In addition the review found that records completed by one NHS agency (a hospital) are not easily available to another NHS agency (the health visitor or another hospital).

This meant there was less focus on Child Y's needs with Staffordshire agencies not taking account of all the information on the lack of parenting ability and commitment. Relevant information was available but there was no attempt to collate it.

Full assessments by a social worker at key times would have demonstrated Child Y's father's hostility and aggression, his dependence on his parents to care for his children, and Child Y's mother's inability to put her child's needs ahead of her own.

The three agencies that have provided services to this family acknowledge that this case has shown that, at times, the child's needs were not at the centre of their communication and assessments.

The view of the panel is that if information had been effectively brought together there would have been a written plan that included clear expectations of the supervision of Child Y's care. It is unlikely however that there would have been sufficient reasons to remove the child from the family and in these circumstances it is not clear that action could have been taken by any agency to prevent the injury to Child Y.

### **4. Lessons to be learnt**

In the research reports *Analysing Child Deaths and Serious Injury through Abuse and Neglect: What can we learn?* (Brandon et al, 2008 and 2009) an analysis of Serious Case Reviews between 2003 – 2005 and 2005 – 2007 there are some lessons to be learnt.

The findings from the first study show that Child Y lived with parents who should have been considered as presenting a 'high risk'.

The characteristics were:

- That Child Y was born prematurely;
  - Child Y had an admission to hospital at a few weeks old, with a serious illness;
  - Child Y's family had a history of drug misuse and violent or aggressive behaviour;
  - Child Y's whole family had tried to avoid contact with children's services
  - Child Y's father had a lengthy history of criminal activity and hostility
- and
- The NHS and Children's Services did not assess Child Y's needs, using all the information that would have helped to measure risk.

The second study added some additional features that were present for Child Y's family. For example that:

- Child Y lived at several addresses;
  - Child Y's father had made an effort to look after his other child but had not been able to sustain his ability to look after Child Y;
  - Agencies tended to stop providing services to families that do not co-operate;
- and
- Agencies had missed the 'whole picture' by not picking up the lack of co-operation with staff in hospitals and the community, which included missing health appointments, and showing some aggressive behaviour.

These lessons have been used to agree the recommendations for all agencies that took part in the review.

## **5. Recommendations from the review**

LSCBs should ensure unborn babies are protected by competent pre-birth risk assessments in circumstances where there is a combination of presenting factors (young parents, parents with chaotic lifestyles, drug misusing parents, parents who do not co-operate with the authorities, missed appointments etc) balanced with protective factors. The level of risk should be recorded and managed accordingly by relevant agencies. These risk assessments should take full account of all history available from all agencies involved and consider the parenting capacity of both parents if they have had other children.

LSCBs should ensure that risks to babies and children are minimised when referrals to and from children's social care are made and received by:

- Checking information for accuracy;
- Identifying clearly all sources of historical information;

- Ensuring core information is gathered before prioritisation and action is agreed;
  - Including information on parenting skills where it is known the parent (either the father or the mother) has a child from a previous relationship;
  - Following agency information sharing protocols, both within and between agencies including within the range of NHS agencies;
  - Assessing levels of risk to babies and children where there are child protection concerns, stating these clearly and sharing them appropriately prior to the baby or child being discharged from hospital;
  - Following up referrals in writing
- and
- Speaking to the sources of the referral as part of the assessment by the social worker.

If the recommendations above make changes to the procedures, all relevant staff should be briefed and the changes should be brought to the attention of all agencies.

Each LSCB that has taken part in this SCR has agreed an Action Plan and will ensure that the recommendations have been fully implemented by September 2010. This has included the Leicestershire and Rutland LSCB which although not involved in providing services has taken the opportunity to quality assure its own arrangements.