



Case Review executive summary

June 2006

INTRODUCTION

This is a summary of a serious case review conducted by ACPC in accord with Part 8 of 'Working Together to Safeguard Children' (1999). It concerns the history pertaining to the accommodation into local authority care of a 15 year old with a background of diagnoses of pervasive developmental disorder, and for whom neglect was an additional feature of care given.

REVIEW

The purpose of the review was to consider the involvement of professional agencies in the provision of services to this young person and to make recommendations for improvements in future practice, policy and procedures in keeping children safe.

The serious case review sub-committee of ACPC comprised of 'The Bridge. Child Care Development Service' commissioned by social services and representatives from social services, the police, health and education.

CASE SUMMARY

The child's early history appears largely unremarkable. This young person was mainly cared for by extended family throughout their childhood, a couple of considerable local social standing, apart from a brief period in the care of birth parents during early infancy. Carers' history was of partial and occasional withdrawal from co-operation with statutory agencies, intermittently enlisting the support of prominent community figures to support their challenges to professional decision making.

Shortly after starting school at 4, professional concern was expressed about learning, ultimately resulting in the child's withdrawal from school at age 6 ½, following which no formal schooling was received until admission to care. A Statement of Special Educational Needs was completed after a number of

years, the recommendations of which were never achieved. Home tutoring was provided until the child was 12, when carers' refusal to co-operate resulted in the service ending.

By 11 the child had received four different diagnoses relating to pervasive developmental disorder. Medical disagreement over diagnosis was never successfully resolved. Extensive health support was maintained over many years although without one, clearly agreed plan for intervention.

Up to the age of 12 social services involvement with this child and family was largely practical. During childhood, a range of professionals raised concerns about the child's mental state and physical care, which did not result in the child protection threshold being seen to have been met, although references to appalling living conditions persisted over time. Inter-agency working did occur but in this case did not make any appreciable difference in attaining better outcomes.

A child protection conference was convened when the young person was 12 to consider escalating concerns, which did not result in the child's name being placed on the child protection register.

Significant concerns and considerable professional involvement continued following that Case Conference although delays in achieving outcomes from agreed plans persisted, with the child's placement in alternative accommodation achieved some considerable time after the decision for alternative care had first been made.

At nearly 16, on admission to local authority care, this young person is said to have presented as "elective mute", apparently unable to walk unaided and with clear signs of physical neglect. Subsequent child protection enquiries did not result in either criminal or civil action being taken.

This young person continues to be looked after and is understood to be making good, even remarkable, progress in this placement.

LESSONS LEARNED

- Fear of alienating carers and difficulties in challenging the views of 'high status' professionals continues to influence professionals' ability to fulfil their statutory safeguarding responsibilities.
- Assessments which lack analysis and specificity do not result in clear needs based, outcome focussed plans of intervention.

- Medical diagnoses should not be viewed as an end result. Diagnosis is most useful in defining “need”, in formulating a plan to meet needs and as a means of reviewing desired outcomes.
- Cases of actual or suspected serious child neglect should be subject to the same rigorous level of child protection enquiry, including police involvement, as concerns about abuse which result from a specific incident.
- Early and formal resolution, to include agreed actions, is required in cases of professional disagreement.
- Where there are multiple numbers of professionals involved with a child, ongoing, co-ordinated and effective inter-agency planning is required, supported by a named ‘lead professional’.
- Decisions and actions should always be triggered by an assessment of need. Reasons for decisions taken should be formally recorded and accountability for decision making made clear.
- Initial assessments of need should not persist over time when challenged by new information requiring robust re-assessment.

RECOMMENDATIONS

- ACPC will promote existing training and recent practice guidance pertaining to issues of child neglect and a primary objective of the emerging LSCB will be to develop a multi-agency strategy for managing issues of child neglect.
- For all cases where there is actual or likely risk of significant harm as a result of neglect, a medical examination under child protection procedures should be sought.
- ACPC to incorporate into a number of existing training opportunities, training which focuses on managing professional conflict.
- LSCB to forward the agenda of the ‘lead professional(s)’ to promote more robust co-ordination of assessments and decision making processes. Health and education should identify a lead professional, to co-ordinate their agencies involvement, where multiple professionals from their service(s) are involved.
- Education staff to ensure that existing systems for the monitoring of children receiving home tuition are complied with.
- Education staff will put in place a system for reviewing complex cases and/or those cases where statementing is not complete.

- All health trusts consider a case management system by which one health professional retains clinical or overview responsibility.
- The Children's Trust Board to progress the issue of joint commissioning.
- Emerging LSCB to consider producing advice regarding the management of professional disagreement, including a process for formal consultation where cases are drifting or there is professional disagreement.
- Vulnerable Children's Service of C+LL to undertake an internal audit regarding compliance with procedures regarding the closure of cases.
- The emerging LSCB to provide a mechanism for monitoring agencies' compliance with their duties under s11 of the Children Act 2004.

LOCAL DEVELOPMENTS

Developing a strategy for tackling child neglect through all tiers of need and services is a specific focus of Staffordshire Children's Trust, Children and Young People's Plan. (2006-2007)

SSCB are hoping to contribute to a national NSPCC project "Improving Joint Practice in Emotional Harm and Neglect."

SSCB have produced detailed "Multi-Agency Good Practice Guidance for Recognising and Responding to Cases of Child Neglect."
(www2.staffordshire.gov.uk/acpc)

SSCB are facilitating training on "Recognition of Neglect" – 16th May 2006, 6th July 2006 and 4th October 2006.

SSCB anticipate an autumn Conference facilitated by "The Bridge Childcare Consultancy" focusing on child neglect. Look out for dates on future flyers.

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