

WAKEFIELD & DISTRICT
safeguarding
children board

**Wakefield & District Safeguarding
Children Board**

**Serious Case Review Executive Summary
in the case of Child M**

January 2009

CONTENTS

Introduction	Page 2
The facts / summary of events	Page 4
Key Issues and themes arising from the case	Page 5
Priorities for learning and change	Page 7
Recommendations for action	Page 8

1. INTRODUCTION

The circumstances that led to this Serious Case Review being undertaken

- 1.1 Child M first became known to specialist services in Wakefield in May 2008, at the age of approximately five weeks old. Child M had sustained a suspected scald to the foot and an investigation was undertaken jointly by Wakefield Council Family Services and West Yorkshire Police. It was subsequently concluded that this injury had been caused accidentally. The criminal investigation was discontinued and the family were referred to a local Family Centre for support in relation to parenting skills.
- 1.2 In August 2008 Child M was taken to A&E by the mother. Child M was seriously ill, and in a state of collapse. Child M was resuscitated and subsequently diagnosed with a perforated bowel. Due to the severity of these injuries, Child M was later transferred to a hospital in Leeds for emergency surgery. Child M has now made a good recovery from these injuries and is safe and well.
- 1.3 Due to concern about the inability of Child M's parents to offer a satisfactory explanation as to how the injuries had occurred, a child protection referral was made to the Safeguarding and Family Support Directorate of Family Services. This was investigated jointly by WMDC Family Services and West Yorkshire Police.
- 1.4 During investigations, it became apparent that Child M had sustained a number of injuries likely to have been caused as a result of physical abuse.
- 1.5 Multi-agency arrangements were immediately put in place to protect Child M from further harm.
- 1.6 In September 2008 the Wakefield and District Safeguarding Children Board convened a Serious Case Review Panel to consider whether the circumstances of the case met the criteria for a Serious Case Review under Chapter 8 of Working Together to Safeguard Children 2006.
- 1.7 The Serious Case Review Panel felt that the criteria stated in Chapter 8 of Working Together to Safeguard Children 2006 were met and recommended that a Serious Case Review be undertaken in order to identify lessons for agencies in relation to safeguarding.
- 1.8 This recommendation was subsequently ratified by the Chair of the Wakefield and District Safeguarding Children Board.

The Serious Case Review process

- 1.9 Composition of the Serious Case Review Panel was as follows:
 - Service Manager – Safeguarding and Family Support Directorate
 - NHS Wakefield District
 - CAFCASS
 - Senior Probation Officer
 - West Yorkshire Police Representative
 - Head Teacher
- 1.10 The author of the Overview report for this Serious Case Review the Service Manager for the Wakefield Youth Development and Support Service.
- 1.11 Individual Management Reviews were undertaken by WMDC Family Services, West Yorkshire Police and NHS Wakefield District, whose overview report describes and analyses the

involvement of all partners within the “health community”.

- 1.12 Additional guidance relating to the independence of chairing of Serious Case Review Panel and authorship of Overview Reports was issued to Local Safeguarding Children Boards by the DCSF in December 2008, at which stage, the majority of this Serious Case Review was completed.
- 1.13 As a result of this communication, the level of independence of the Serious Case Review Panel Chair and Overview Author were insufficient because although independent of the case of Child M, both were members of the Local Safeguarding Children Board. In accordance with the new guidance, all Serious Case Review documents were submitted for feedback and challenge to a fully independent safeguarding expert in January 2009.
- 1.14 The full Serious Case Review panel met on five occasions to give challenge and quality assurance to the process and to the documents submitted.
- 1.15 The Serious Case Review was completed in January 2009 and an Action Plan was implemented for those agencies involved in the case, to ensure that the recommendations made within the Serious Case Review were implemented without delay. This Action Plan has been monitored by the Wakefield and District Safeguarding Children Board.

2 The facts/summary of key events

- 2.1 At the time of the incident that led to this Serious Case Review, Child M lived with the mother and her partner.
- 2.2 In May 2008 Child M was presented at the Accident and Emergency Department of the local hospital with a foot injury. The injury was reviewed by a Paediatric Consultant and at this stage, the likely diagnosis was a scald.
- 2.3 The Paediatric Registrar subsequently made a Child Protection referral to Wakefield Council’s Family Services Department due to the fact that no adequate explanation could be offered for the injury.
- 2.4 This injury was investigated jointly by Family Services and West Yorkshire Police. A Strategy Meeting was held to enable professionals to discuss the case, and subsequently, it was concluded that the scald was likely to have been caused accidentally by mother’s partner when hot water was spilled during feeding.
- 2.5 As a result, Child M returned home, and the family were referred to a local Family Centre for support in relation to parenting skills.
- 2.6 In August 2008 Child M was admitted to hospital again with serious injuries that were assessed as likely to have arisen as a result of physical abuse.

3 Key issues or themes arising from the case

- 3.1 This Serious Case Review has found that Child M’s admission to hospital with a scald in May 2008 was an opportunity for professionals to safeguard Child M that was missed by all agencies. The key themes arising from the analysis undertaken within the Serious Case Review process are detailed in the following section of this Executive Summary.

Communication between professionals within the same agency

- 3.2 The Serious Case Review has highlighted a number of occasions where a lack of

communication between professionals within a single agency has impacted on the assessment of risk and subsequent planning for Child M.

- 3.3 Following Child M's first admission to hospital in respect of the scald there are a number of occasions where formal discussion between medical professionals should have taken place according to procedures. The purpose of this discussion, which according to procedures should have been instigated by the Consultant Paediatrician, would have been to share information and medical opinion, and to arrive at a shared diagnosis of the injury and its possible causes.
- 3.4 However such discussion did not take place, and the Consultant Paediatrician did not speak directly to the specialist medical professionals. This was particularly crucial given the fact that the Consultant Paediatrician and Plastic Surgeon had different views about the possible causation of the injury.
- 3.5 Within the hospital setting, there are a number of Named Professionals whose role is to provide specialist expertise and advice in relation to safeguarding matters. At no stage was a Named Doctor consulted about the injury to Child M's foot.
- 3.6 The Strategy Meeting held on 7th May 2008 would have presented a further opportunity for medical professionals to have come together to discuss their findings. However, the fact that a number of key people were absent meant that this discussion and challenge did not take place. As a result, the value of this meeting in contributing to a shared understanding of the case and the risk to Child M was affected.

Communication between professionals in different agencies

- 3.7 The Serious Case Review has found a number of occasions where professionals were diligent in sharing information with colleagues in different professions or agencies. For example, It is evident that after Child M's discharge from hospital, staff in the local Health Visiting Team pro-actively shared and sought information from their colleagues within Family Services. The Health Visiting Team initiated contact with Family Services on seven occasions between May and July 2008 and shared increasing concern in an appropriate manner. There is also evidence of good communication between the health visiting staff and the GP practice.
- 3.8 The initial involvement of Social Workers evidences good inter-agency communication. There were timely and appropriate strategy discussions involving police colleagues as well as ongoing liaison. There is evidence of good communication between the Social Workers and the Consultant Paediatrician. Similarly, the Initial Response Team Social Worker was diligent in ensuring that contact with medical staff and police was maintained.
- 3.9 However It is a finding of this Serious Case Review that there were a number of opportunities for professionals in different agencies to communicate with each other that were not taken or where understanding of the views of another professional was limited. If communication between professionals had been stronger, it is possible that the apparent confusion about the nature and causality of Child M's foot injury could have been resolved, leading to a clearer assessment of risk and stronger plans being made to safeguard the child in the future.

Professional challenge

- 3.10 The Serious Case Review has found that at times, a lack of challenge between professionals within a single agency and between different agencies and professions has been a feature of this case and has resulted in missed opportunities to develop a fuller understanding of the risks to Child M.
- 3.11 From the date of the first injury to Child M, health care professionals adopted inconsistent opinions in respect of the cause of the injury to Child M's foot and in relation to the results of the skeletal survey. Despite these inconsistencies, and the seriousness of the situation and

possible implications of their diagnosis and opinion, the key doctors did not at any stage speak directly to each other about their findings.

- 3.12 Safeguarding practice would have been strengthened if the case had been escalated to a Named Safeguarding Professional within the Trust. This would have provided an opportunity for the Named Safeguarding Professional to bring the doctors together and provide a clearer opinion. This did not happen in this case and resulted in a missed opportunity to share clear information to help professionals fully understand the potential risks to Child M and formulate plans to mitigate the risks.
- 3.13 Within Family Services, the level of management challenge within the Initial Response Team appears to have been limited. We are aware that the Social Worker discussed the case on several occasions with her line manager, although not all of these discussions are recorded. However there is no evidence that the assessment, particularly the conclusion that Child M's injury was accidental, was challenged or questioned to any significant degree. More rigorous case discussion and challenge through the supervisory process could have provided an opportunity to more fully understand the risks to Child M. More robust challenge from a team manager with broader safeguarding experience may have resulted in a less definite conclusion of accidental injury.

Management oversight and supervision

- 3.14 Within Family Services, case records show that the Initial Response Team Social Worker and Team Manager appropriately discussed the case of Child M in formal supervision sessions on three occasions. In addition, there are records of discussion in-between formal supervision sessions. Key decisions taken by the Social Worker were supported by the Team Manager. However the Serious Case Review has found that the Team Manager should have provided a greater level of challenge to the findings of the assessment undertaken by the Social Worker.
- 3.15 The primary responsibility for the escalation of the case to the Named Safeguarding Professional within health rests with the doctors involved. However a greater level of challenge to the Initial Response Team Social Worker by the Team Manager could have enabled the Team Manager to escalate the case to more senior medical professionals. This may have resulted in greater clarity.
- 3.16 Following the scald, the police investigation was "signed off" and closed by a Detective Sergeant rather than a Detective Inspector. This is not in line with police procedures and represents a missed opportunity for the assessment to be challenged by a more senior officer.

Assessment and Analysis of Risk

- 3.17 The Serious Case Review has found that the assessment undertaken by the Initial Response Team Social Worker would have been strengthened by more effective utilisation of the information available from a wide range of sources. In particular, the Serious Case Review has found that the lack of any information relating to the past history of either parent as a significant failing. Both parents had previous contact with agencies which, although it would not have indicated a risk to Child M, would have identified them as a potentially vulnerable family needing a higher level of support.
- 3.18 The Serious Case Review has found that the assessment was superficial and did not have the level of analysis that was warranted. The Core Assessment does not convey any real sense of the family, of the parent's personalities, strengths, weaknesses etc.
- 3.19 The Serious Case Review has also found that the findings of the Initial Response Team Social Worker were overly optimistic, and did not fully recognise that although medical professionals had indicated that the mother's partner's account of Child M's injury was plausible, the possibility that the injury had arisen as a result of abuse had not been ruled out, particularly

given the conflicting opinions of medical professionals at different stages in the case. There is evidence to suggest that in this case, the account offered by the father was not the subject of rigorous challenge or exploration and was accepted too readily by professionals in all the agencies.

Safeguarding Children Procedures

- 3.20 The Serious Case Review has found that the Wakefield and District Safeguarding Children Board has collaborated with other Safeguarding Children Boards in West Yorkshire to produce shared, multi-agency procedures that are comprehensive and up to date. Failings in this case did not relate to failings in procedure.
- 3.21 The Serious Case Review has found a number of examples of occasions when these procedures were followed extremely well by staff but on other occasions, procedures were not adhered to fully.

Timeliness of Intervention

- 3.22 This Serious Case Review has found evidence of good practice in all agencies in relation to the timeliness of their interventions. Investigations and assessments were undertaken promptly and in line with statutory guidance contained in Working Together to Safeguard Children 2006.

Diversity

- 3.23 All the Individual Management Reviews submitted to the Serious Case Review have examined whether issues related to diversity have played any part in this case. The Serious Case review finds that cultural and diversity issues were not a factor in the injuries sustained by Child M or the agencies response, and no lessons in this respect have been identified.

Consultation with Family Members

- 3.24 Following the close of the criminal proceedings, the author had the opportunity to meet with Child M's mother and her partner in order to seek their views and provide them with information relating to the findings of the Serious Case Review. The views expressed in relation to their experience of service provision have been shared with the Safeguarding Children Board.

4 Priorities for Learning and Change

- 4.1 The Serious Case Review has highlighted learning for all the agencies involved in this case in relation to how they work individually and collectively to identify and safeguard children who are at risk of abuse. The key areas identified for change within agencies of the Wakefield and District Safeguarding Children Board are:
- The issue of how medical opinion in child protection cases is requested, provided, processed and used to formulate plans to safeguard children
 - The way in which professionals within agencies and across agencies are able to rigorously challenge the opinions and assessments of other professionals
 - The need for managers and seniors in all agencies to provide rigorous "quality assurance" and challenge to the work of their staff
 - The quality of assessment and planning and in particular, the need to use information from all available sources, including historical information relating to parents and extended family

- The degree to which staff compliance with policy and procedures is monitored and challenged within agencies.

5 Recommendations for action

NHS Wakefield District Wakefield District

- 5.1 The Chief Executive of NHS Wakefield District should ensure that record keeping is undertaken in accordance with existing Professional Codes of Conduct and Trust Policies.
- 5.2 The Director of Nursing / Chief Nurse should ensure that a Safeguarding Children Supervision Policy and Procedure are in place, and that compliance with this policy is regularly reviewed and reported within the Governance Structures of the Health Trust
- 5.3 The Lead Commissioner for Children should ensure that a Paediatric Liaison system is in place before the end of March 2009.
- 5.4 The Modernisation Manager and Head of Health Improvement should ensure that the format of Health Visitor records incorporates the Common Assessment Framework, and that Health Visitors are skilled to undertake assessments under the framework.
- 5.5 The Modernisation Manager and Head of Health Improvement should ensure that the format of Health Visitor records incorporates information regarding a child / family's:
 - Ethnic and Cultural background;
 - Religious beliefs; and
 - Language of choice.
- 5.6 The Modernisation Manager and Head of Health Improvement should ensure that Health Visitors assess, update and record information regarding a child's father / father figure.
- 5.7 The Chief Operating Officer will ensure there is a Policy and Procedure for the management of families where 'closure' is identified.
- 5.8 The Named Nurse should ensure that all safeguarding children training delivered within the organisation addresses the issue of 'Closure' within families.
- 5.9 The Locality Manager/s should identify lessons to be learnt from the systemic failure highlighted in this review that led to a failure to identify clinic non-attendance.

The Mid Yorkshire Hospitals NHS Trust

- 5.10 The Professional Executives (Chief Nurse and Medical Director) of Mid Yorkshire Hospitals Trust should ensure that record keeping is undertaken in accordance with Professional Codes of Conduct and Trust Policies. This will require changes to procedure and guidance, and a method of auditing whether this results in changes in practice.
- 5.11 The Director of Nursing / Chief Nurse should ensure that a Safeguarding Children Supervision Policy and Procedure are in place, and that compliance with this policy is regularly reviewed and reported within the Governance Structures of the Health Trust, to ensure that staff receive the appropriate levels of support and guidance.
- 5.12 The Head of Midwifery within the Mid Yorkshire Hospitals NHS Trust should ensure that maternity records incorporate assessment tools to enable midwives to evaluate a pregnant woman's family and social support.

- 5.13 In relation to the issue of “difference of medical opinion” which is key to this case, the Professional Executives (Chief Nurse and Medical Director) of Mid Yorkshire Hospitals Trust should ensure that all relevant staff are aware of the need to seek advice from a Named Professional in cases where a difference of medical opinion arises. The Trust should then provide assurance and evidence to the Wakefield Safeguarding Children Board regarding the position of the Trust in this respect.
- 5.14 The Clinical Director for Radiology should ensure that a protocol is in place for the undertaking of skeletal surveys for children.

West Yorkshire Police

- 5.15 The Police should ensure that the reviewing and finalising of investigations is always undertaken by an officer of more senior rank than the investigating officer to enable a greater level of challenge to be applied to the conclusions that are reached in child protection cases.
- 5.16 WY Police should issue guidance to staff to ensure that all decisions and reasons/analysis are clearly and fully recorded on the Police’s VIVID system prior to finalisation of the investigation.

WMDC Family Services – Safeguarding and Family Support Directorate

- 5.17 WMDC Family Services should take the lead in producing a strong guidance document that serves to guide the actions of social care staff in relation to the issue of medical diagnosis in child protection cases. This multi-purpose document should:
- Make social workers aware of the systems and procedures in place within the Mid Yorkshire Hospitals NHS Trust in relation to this issue
 - Make these professionals aware of the steps that should be taken when there is any problem or concern in relation to diagnosis

This document should be completed in collaboration with the relevant partners.

After the document has been distributed to all relevant staff members in the Safeguarding and Family Support Directorate of Family Services, the Wakefield and District Safeguarding Children Board should formally monitor this issue to ensure that practice has improved.

- 5.18 The need for Social Care Direct to provide a full Transfer Summary for the new team at the point of transfer of a case involving child welfare concern should be clearly written into Family Services procedures. This would help to ensure that both factual information, as well as information relating to level of concern, is transferred and clearly understood by the next team to become involved in the case.
- 5.19 The Transfer Protocol within Family Services should be amended, to make it a procedural requirement that when transferring a high priority case to an Initial Response Team, Social Care Direct will always initiate a direct discussion with the Initial Response Team Manager. This will reduce the risk of delay in allocation, or misinterpretation of level of concern.
- 5.20 Family Services should issue a clear instruction to all Team Managers and social workers to record management decisions on case files and compliance with this requirement should be regularly audited by senior managers.
- 5.21 In future, the quality of Core Assessments should be formally audited by Team and Senior Managers. This will enable Family Services to identify and address any common themes relating to quality of core assessment, and will also enable any individual performance issues to be addressed promptly.

- 5.22 Compliance with the procedural requirement that all Child in Need cases have an active CIN Plan should be tested by its inclusion as a specific item in case file audits by Service Managers, to ensure that the agreed practice is being followed in all cases.