

ISLE OF WIGHT SAFEGUARDING CHILDREN BOARD



RESTRICTED - PERSONAL

SERIOUS CASE REVIEW

Executive Summary

Name of Child:

Child D

REPORT AUTHOR:

Brian Boxall

Associate of In-Trac Training and Consultancy Ltd

**This report is confidential and should not be shared without the permission of
the Chair of the Isle of Wight Safeguarding Children Board**

1 EXECUTIVE SUMMARY

Circumstances leading to the review

- 1.1. In December 2008, Child D, who was twelve weeks old, was taken by her mother to her local hospital at the request of her general practitioner. The general practitioner had identified unexplained bruising.
- 1.2. Upon examination the child was found to have suffered 16 separate fractures, including 15 rib fractures. The injuries indicated different stages of healing some were thought to have been up to four weeks old.
- 1.3. Child D was detained in hospital. Mother was 17 years old, and father was 19 years old.
- 1.4. Chapter 8 of ¹'Working together 2006' sets out the circumstances when a Local Safeguarding Children Board should consider undertaking a Serious Case Review. They include when:

A child sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse of neglect

or

the case gives rise to concerns about inter-agency working to protect children from harm

- 1.5. The purpose of a Serious Case review is to:
 - *Establish what lessons are to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children;*
 - *Identify what those lessons are both within and between agencies, how and within what time scales they will acted upon, and what is expected to change as a result; and*
 - *Improve intra-and inter agency working and better safeguard and promote the welfare of children*

¹ HMG (2006) 'Working Together to Safeguard Children' TSO

- 1.6. David Parkinson, the Independent Chair of the Isle of Wight Safeguarding Children, at that time, agreed to instigate a Serious Case Review in line with Chapter 8 following a recommendation from the Serious Case Review Working Group. This occurred on the 9th February 2009. The review was therefore commenced prior to the revised 'Working Together 2010' guidance.
- 1.7. The Terms of Reference set the scope of the review to cover the period from the 1st January 2008 to 11th December 2008. This covered mother's pregnancy through to the birth of Child D. The time period was later amended, to commence from the 1st January 2007. This, it was felt, better reflected the lead up to mother becoming pregnant and issues relating to her schooling. This change was supported by the panel.

2 The Serious Case Review Process

Serious Case Review Panel

- 2.1. The Serious Case Review Working Group appointed a panel to oversee the process of the review. Keith Akerman was appointed as the independent panel chair and Brian Boxall as the independent overview author. He is an associate of In-Trac Training & Consultancy Ltd. and an ex senior police officer with number of years service.
- 2.2. The panel consisted of:
- Independent Chair
 - Associate Director - Child, Family & Therapy Services – Isle of Wight NHS
 - Principal Lawyer, Social Care Legal Team
 - Chief Fire Officer – IW Fire & Rescue Service (Independent)
 - Commissioner for Workforce Development – Isle of Wight Council, Children & Young People's Directorate
 - Detective Inspector – Hampshire Constabulary
 - Chief Executive, Hampton Trust. (Voluntary sector organisation)
 - Principal Officer: Quality Assurance & Information – Isle of Wight Council, Children & Young People's Directorate

Non-Panel Members:-

- Board Manager – Isle of Wight Local Safeguarding Children Board.
- Operational Support Officer – Isle of Wight Local Safeguarding Children Board.

It is of note that two of the members represented agencies that had no involvement whatsoever with the case and were able to provide some additional strong independent thinking to the panel. This was good practice.

2.3. Individual Management Reviews (IMRs) were initially requested from :

- Hampshire Constabulary
- Children's Social Care Service
- Mental Health and Learning Disabilities Directorate
- Paediatric Services
- Health Visiting Services
- General Practice
- Maternity Services
- Education Welfare Service
- Schools

An additional Individual Management Review was subsequently requested from the Mental Health and Learning Disabilities Directorate when their significant involvement with family members became apparent.

Contributions / Professional Involvement

2.4. Both the panel members and the overview author had an opportunity to speak with some of the Individual Management Review authors and to review, as a group, the agencies' reviews to provide some quality assurance to the process. This resulted in additional information being sought from the authors. The Individual Management Review authors had also interviewed relevant members of staff.

Family Involvement

2.5. The author was able to meet with the mother and father of Child D. An independent advocate was used to assist the process. They were provided with a resume of the interview and informed that they would be spoken to by either the author or a member of the Safeguarding Board when the report was completed. Other family members were considered but were not progressed as the author felt that they would not have added significantly to the process.

2.6. Many of the recommendations contained within the Individual Management Reviews have been progressed prior to the completion of the serious case review.

3 SUMMARY OF AGENCY INVOLVEMENT

- 3.1. All the members of the family involved in this case still reside in the local area. In order to maintain their anonymity and to conform to the Data Protection Act 1998 this summary has had to be restricted.

The family members will be referred to as follows:

Child D as Child D

Mother of Child D as mother

Father of Child D as father

Maternal Grandfather of Child D as MGF

Maternal Grandmother of Child D as MGM

All the family members were white British

- 3.2. Mother was born in 1991 and subject to a Care Order between the ages of 7 and 11. This was as a result of her mother (MGM) not being able to cope due to mental health problems. A Residence Order was eventually granted to MGF (Child D's Maternal Grandfather) in respect of all his children.
- 3.3. In 2006 Mother's attendance at school started to drop below the acceptable level. The school involved the Educational Welfare Service. They worked with MGF to try and improve her level of attendance. Whilst it improved slightly, the Educational Welfare Service remained involved. While still at school, mother became pregnant. She was 16 years old at the time.
- 3.4. Child D was born in September 2008, by that time, the mother was 17 years old and the father of Child D was 19 years old.
- 3.5. The agencies involved with mother and Child D, (school, Education Welfare Service and the health professionals) judged mother to have been a bright individual who was able to cope and required no specialist attention. Father and the rest of her family were seen as being supportive of her.
- 3.6. Immediately after the birth Child D and mother lived with MGF. After a few weeks both mother and father of Child D moved in together into a new address. Police were

called to the new address on a couple of occasions during November 2008. The first time was to a report of a noisy party. The informant stated that they could smell cannabis emanating from the premises. They also raised a concern that there may have been a young baby at the premises. Police did not attend. On the second occasion the parents were reported to be having a domestic dispute. Police did attend on this occasion and confirmed that Child D was not at the home address at the time. No further action was taken but information about both incidents was passed to the Children's Social Care Service.

3.7. In December 2008, mother took Child D to her general practitioner having been advised to do so by a member of the public who had seen a bruise on Child D. The general practitioner was so concerned about the bruising that he arranged for mother to take baby to the local hospital children's ward for further examination of the marks. Mother attended and the full extent of the injuries to Child D was identified. A number of the injuries were considered to have been up to four weeks of old.

3.8. Health professionals had seen Child D on a number of occasions during routine appointments, prior to the identification of the injuries in December.

Good Practice

3.9. As there is in any review, there were a number of areas of good practice identified. These should be highlighted in this review.

- Hampshire police officers, when they attended the domestic dispute had clearly identified a potential risk posed to a young baby. They not only established that the child was not present, they went and confirmed this.
- The general practitioner who identified the bruising in December made a referral to the children's ward. This was an important observation leading to the prevention of further abuse.
- The safeguarding midwife who advised the consultant to make a referral to the Children's Social Care Service.

4 LESSONS LEARNT/CONCLUSION

4.1. This review has highlighted a number of issues from which lessons can be learnt.

4.2. This serious case review was commissioned in response to the serious injuries inflicted upon child D. Whilst no individual has been convicted of causing the injuries,

and the perpetrator remains unknown at this time, it is clear from the medical evidence that the injuries sustained were non accidental and that considerable force/pressure needed to have been administered for them to have occurred.

- 4.3. In considering the issues of Child D, the review has rightly focused on the child's parents in respect of teenage pregnancy and their ability as young people to be able to parent Child D appropriately.
- 4.4. There is an overwhelming feeling, highlighted in both the overview and individual management reviews, that the needs of mother, who was only 16 years old when she became pregnant, were not fully identified nor acknowledged by the system.
- 4.5. Whilst it was recognised that she was a young mother, her family background and her life experiences were never fully taken into account. Any assessments of her needs as a child in her own right were taken from a perception of her being a bright capable, compliant individual who was able to cope and happy to be pregnant.
- 4.6. These were assumptions which, when her background was taken into account, were not fully supported. She was a young person who, due to what she had experienced during her young life, needed to be supported through pregnancy and following the birth of child D. The support processes, in the main, were restricted to her clinical needs and those of the baby. Not fully assessing her needs and providing her with the support she needed potentially placed Child D at risk.
- 4.7. This applied equally to the father. Again, there were assumptions made about him and he was considered to be a supportive partner, but he was never spoken to and his history was never considered. His offending behaviour indicated that he could be aggressive when he had been drinking. Any potential risk posed to Child D was never considered.
- 4.8. **Lesson:** Any assessments of a pregnant teenager must take into account their family background. The individual must be spoken to and given the opportunity to explore their needs and fears.
Lesson: Both parents need to be supported. The father is as important as mother and has the same fears and needs. They need support to help them to become good parents.

- 4.9. There was no joined up multi agency approach/protocol to dealing with teenage pregnancy. This led to a single agency approach dealing with only their part of the process; school focusing on her education, Education Welfare Service her truancy and the Universal Health Services on her clinical needs. There was no clarity concerning who should be taking on which aspect, and who should have taken the 'professional lead' to collate the response to mother's needs and that of the unborn child.
- 4.10. **Lesson:** There should be a joined up approach to teenage pregnancy and teenage parents with every agency understanding their role within it. A clear multi agency protocol would assist clarity of understanding.
- 4.11. When the parents moved to a new address and there was a report of noisy party followed by a report of a domestic argument, there was no real assessment of the effect that this may be having on a very young baby. The 'risk' for the second incident was considered to be minimal because the child was not present, but these events could indicate a young couple who were struggling to cope with the needs of a young baby.
- 4.12. **Lesson:** Incidences of domestic violence or untoward incidences at premises where a young child is resident should be investigated, even if the child was not present.
- 4.13. The young parents felt that the services they were accessing, antenatal and post natal clinics, were very much 'adult focused' and that individuals were judging them as young parents. They did not feel they were being supported but judged.
- 4.14. **Lesson:** Young teenage parents need to be supported in an environment in which they feel comfortable and supported. Adult centred services may not achieve this without additional teenage focused support.
- 4.15. As was highlighted, an important function of the Children's Social Care Service, the assessment process, was under significant pressure due to the workload and the lack of staff with one team manager being responsible for overseeing all assessments.
- 4.16. **Lesson:** When this level of pressure is identified within any agency child protection process, action must be taken to reduce the pressure and thereby future risk. If it is

not addressed it will leads to undue pressure and potential damage to staff and risks to the child protection process.

- 4.17. Poor recording has also been identified within a number of agencies. Failure to record accurately does effect the ability of individuals to understand what has taken place; and give consideration to important information that may be vital when undertaking assessments.
- 4.18. **Lesson:** All staff should record interactions between themselves and the client and other agencies accurately.
- 4.19. The consequences of not identifying the needs of the whole family was to put Child D in a position where she could have received very serious injuries. Who inflicted those injuries has not been established but the assumptions about parents and their support structures, based on very little evidence, left Child D vulnerable. This is not the fault of any one agency but a combination of all the agencies, none of whom took the professional lead and undertook a full assessment of needs.
- 4.20. Many of these lessons are contained within the individual Management Review agency recommendations, and due to the extended time between the start and completion of the review many of the recommendations have already been implemented. This should reduce the opportunities for this set of circumstances to be replicated.

10 OVERVIEW REPORT RECOMMENDATIONS

Recommendations: The Isle of Wight Safeguarding Children Board

1. The Isle of Wight Safeguarding Children Board to review their current Serious Case Review process. To include the requirement to consider, within each individual management review, issues of race, language, culture, religion and disability taking into consideration any specific issues.
2. The Isle of Wight Safeguarding Children Board:
 - Produce a local multi agency protocol to ensure the responsibilities of each agency are explicit when responding to pregnant teenagers. To include how they should

effectively work together.

- Review and audit teenage pregnancy cases to consider the quality of assessment and multi-agency working.
- Review section six of the 'Thresholds for Access to Services document' to take account of current practice regarding Common Assessments offered on all teenage pregnancies.
- Ensure that young people are more involved in service development around teenage pregnancy services.

3. The Isle of Wight Safeguarding Children Board in conjunction with their partners to review the 4LSCB procedures, in light of the issues raised in this review, to:

- Consider the current referral time frames as set out in 3.4.24 of the Procedures,
- Ensure procedures are sufficiently clear with regard to reporting of domestic abuse when there are children in a family.
- To review the 4 LSCB Bruising Protocol.

To ensure that all agencies:

- Make sure that their staff are aware of the process that is undertaken when they submit referrals/contacts and that each agency have in place quality control process applied to their referrals.
- Make sure that their staff are aware of how to challenge decisions re referrals they submit.

4. The Isle of Wight Local Safeguarding Children Board with its constituent partners to review the current contact/referral process with regard contacts from the Police (CYPRs) to ensure that cases are not overlooked.

5. The Isle of Wight Local Safeguarding Children Board to be made fully aware that information sharing weaknesses, as identified in a previous serious case review, have reoccurred in this case and as a result a report to the board should be undertaken to reassure them that the necessary policy and practice has been amended.

6. The Isle of Wight Local Safeguarding Children Board to request that the Children's Trust evaluate the progress that multi-agency early intervention / locality teams are having on the referral rate to tier three and four services.

The implementation of the following recommendations to be monitored by the Isle of Wight Safeguarding Children Board

Recommendations: Primary Care Trust

1. The Primary Care Trust to ensure that the 4LSCB procedural guidance: *'Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health'* is reinforced and is being implemented, and that general practitioners as a matter of course should record that this has taken place.

Recommendations: All Agencies

2. All agencies to reinforce to their staff the need to take equal account of the males within the family context when undertaking assessments and to report back to the Safeguarding Children Board within 6 months on actions taken.
3. All agencies to identify areas of pressure that may affect their ability to safeguard children i.e. staffing levels against workloads, experience and supervision levels and report to the board how they will address any concerns through exception reporting.

INDIVIDUAL MANAGEMENT REVIEW RECOMMENDATIONS

The following are the recommendations as set out in each of the individual management reviews.

Recommendations: Children's Social Care Services

1. That the findings of this review and associated lessons are circulated across children's social care practice fora and used to embed lessons learned in practice particularly those related to ensuring practice complies with procedures.
2. That a senior children's social care manager is tasked by the interim Deputy Director, Safeguarding (IDD Safeguarding) to:
 - a) assemble and collate an exhaustive list of local practice guidance, threshold criteria and action points from previous reviews, including the business process embedded in the ICS used on the island, and check that these are fully compliant with the latest 4LSCB procedures.
 - b) using the outcome from a) above, make corrections to local practice guidance,

threshold criteria, and ICS business requirements incorporating action points from previous reviews, in consultation with the LSCB, where any lack of compliance with 4LSCB procedures is detected.

c) ensure that revised local practice guidance, resulting from b) above, is communicated to all relevant children's services teams and key contacts in partner agencies.

d) ensure that changes are made in safeguarding practice where required as identified in c) above, are implemented and embedded in practice, and audited.

e) Develop a workload management strategy that would enable senior officers to assess workloads effectively

3. That Workforce Development are given the task of developing and delivering a Safeguarding practitioners training programme, in consultation with the LSCB:
 - That is genuinely multi-agency.
 - That is readily available, runs on a regular repeating cycle and is easily accessed.
 - That is based on a set of required worker minimum capability standards drawn up in partnership with the LSCB.
 - That is built up from a series of modules, meeting the needs of workers in different agencies to access training at different levels, from induction through to advanced and specialist.
 - That is updated regularly to incorporate any lessons learnt, changes in guidance, procedures and statutory duties.
 - That safeguarding training at advanced levels incorporates relevant risk analysis training.

4. That children's social care managers, through the Personal Development Review (PDR), ensure that all workers in their teams have accessed the appropriate level of safeguarding training, to make certain:
 - that newly appointed social workers access induction training within 3 months of taking up post.
 - that newly qualified social workers, wherever possible, undergo induction training before taking up qualified posts, e.g. whilst waiting for confirmation of their social work registration.

- that all safeguarding workers and managers are engaged in a process of continual practice development which includes attendance at safeguarding training at intervals never greater than 2 years.
- that specialist training, e.g. Achieving Best Evidence Interviewing, is available on a regular basis across front line social work teams, as part of workers advanced professional development.
- That the Deputy Director, Safeguarding receives reports on the delivery of safeguarding training, identifying compliance and non-compliance with this recommendation.

This is to be embedded in the next round of PDRs.

5. That Senior Managers in safeguarding services ensure that the required standards in terms of regular case auditing within teams are achieved on a monthly basis. Any failure to achieve the required standards must be explored and resolved in supervision.

That good practice and poor practice identified through the monthly file audit system and the 3 monthly senior managers' case audits is fed back to workers and any outstanding issues addressed through the formal supervision system.

That the Principal Officer, Safeguarding regularly carries out random audits of the outcomes to contacts, including scrutiny of the time taken to record and implement an outcome, using the Corbusiness system (Local Authority Performance Management System)

Recommendations: Education Welfare Service

1. The EWS practice guidance is reviewed and revised to ensure that the following key points are included and clarity established with regard to the following;
 - The roles and responsibilities of the EWS and Schools in respect of managing school attendance, and clearly identifying the respective roles in regard to welfare and pastoral support of students, and specifically in respect of vulnerable teenage parents known to, or clients of the EWS.
 - The thresholds for EWS practice in respect of; school referrals, when cases should be escalated from low to high level support category management oversight at each stage and when CAFs or more intensive assessments should be undertaken.

Seeking and recording the views of individual children or young people to inform child

centred practice.

2. EWS case and information management processes are updated to address the following key points;
 - Safe storage of client files
 - Required management oversight and sign off of all client files prior to closure
 - Cross referencing of files where more than one family member is known to the service at point of allocation. This then informs intervention.
 - All information relating to EWS action is contained in one case file, therefore notes of school meetings are incorporated into the case file.
3. That supervision and recording procedures for EWS are updated and ensure;
 - That recording standards meet with Local Authority standards.
 - That supervision standards are compliant with the Local Authority Childrens Services Supervision policy.
4. That all EWS staff undertake training in respect of;
 - CAF and the role of the Lead Professional
 - Data Protection
 - Information Sharing – when, what and how to share
 - Child Development theory and practice
 - Risk Assessment and Child Protection Practice

Recommendations: SpCAMHS

1. Ensure the Lead Nurse in Mental Health & Learning Disability implements the principles contained in Social Care Institute for Excellence (SCIE) Think Child, think parent, think family: a guide to parental mental health and child welfare (2009)
2. Produce a referral pathway between Specialist CAMHS and Acknowledging Early Signs of Psychosis Service (AESOP) to identify vulnerable children / families
3. Through briefing sessions, Inform Service Leads of Lessons Learnt from this serious case review.

Recommendations: General Practice

1. Policy to be agreed on how children suspected of being injured or abused are transported from Community / Primary Care settings to the Hospital for further investigations
2. The referral to the Assessment & Intervention Team is made as early as possible by the professional raising the initial concerns of bruising in a non ambulant child as per the 4LSCB Policy
3. Youth at Risk reports are collated and evaluated by the Named Nurse for Safeguarding Children and shared with the attached health visitor who will inform the GP of the details either face to face or via e mail
4. GPs to invite their allocated Health Visitors to the clinical meetings to discuss Safeguarding Children issues that arise and share information about families of concern.
5. A review is undertaken by the GP in conjunction with universal services when the GP is aware / notified that a child has not attended for the 6 – 8 week medical review.

Recommendations: Health Visiting

1. An Ante Natal visit to be carried out on all teenage pregnancy (under the age of 18 yrs) clients between 32 – 36 weeks gestation
2. To review the management and delivery of services within named Baby Clinic to ensure it is in accordance with identified best practice[Healthy Child Programme]
3. To ensure volunteers are only used in a support role at Well Baby Clinics and that qualified staff assess babies/children.
4. To ensure regular monitoring of all outcomes of referrals to the Children Centre Family Link workers by the Named Health Visitor.

Recommendations: Maternity

1. Ensure information is taken at booking & throughout the pregnancy in relation to social history/ background.

Ensure a facility is in the records to explore family history in relation to abuse, mental health or alcoholism in mothers own family.

2. Ensure the use of a Pre CAF or CAF for ALL pregnancies for those booking under the age of 18.
3. Ensure all discharge information from the Maternity service, both in hospital and the community, must be clearly documented within the main body of the notes.
4. Any author of an entry in a clinical / health record is clearly and easily identifiable (applicable for all staff medical and midwifery) as per existing health records guidance.
5. Mandatory Safeguarding children training to be undertaken by all midwifery staff in line with the NHS IOW Safeguarding Children Training Policy (2009).
6. To raise awareness amongst maternity services staff with regard to the Serious Case Reviews process.

Recommendations: Paediatrics

1. Guidance to be written on how children suspected of being injured or abused are transported from Community / Primary Care settings to the Hospital for further investigations.
2. When a referral is made to the Children's Unit for children who are suspected of being injured or abused, written sensitive referral information should be faxed or emailed with appropriate precautions and not given to the parent / carer to transport.
3. Whenever bruising is identified or suspected in a non ambulant infant a referral is made to Children's Services Social Care at the earliest opportunity by the health professional raising the initial concerns.
4. The Integrated Care Pathway (ICP) is adapted to ensure that all information relating to possible abuse/Non Accidental Injury is recorded in a logical, easily audited manner

that includes checklists and prompts of key information to be recorded.

Recommendations: Police

1. Force Policy 09010 to be revised to ensure that all CYPR are either as a result of a visit to a child or initiate a visit to a child following identification that the child is at risk.

Recommendations: High School

1. High School should ensure that a minimum standard for record keeping is developed and implemented by December 09. This should include guidance to staff about which significant events should be recorded.
2. High School should ensure that senior managers review progress monthly against planned actions (agreed in weekly joint meetings) and follow up with the EWS service, if timeframes for actions agreed in the interface meetings have not been met.
3. The Children's Trust should ensure a protocol is in place between the agencies dealing with pregnant teenagers of statutory school age. It will ensure a full assessment of the young person's needs is made to include a review of the range of alternative provision for the young person to continue in education up to and post birth.
4. High School should ensure that safeguarding training is available for its staff, which ensures they are aware of:
 - potential indicators of abuse
 - Thresholds for accessing additional support for vulnerable pupils (as identified in child health promotion programme)
 - The referral process onto other services.