Executive Summary of Serious Case Review

Child W
1. Circumstances of the Review

This Serious Case Review was commissioned by Rotherham Safeguarding Children Board (RSCB) following the admission to hospital, in early 2007, of a four month old baby with injuries consistent with violent shaking. Medical opinion indicated the injuries could not have been caused accidentally and a child protection investigation was commenced.

At the time of the incident Child W and his two older siblings were the subjects of child protection plans in the category of neglect. Applications for Care Orders were subsequently made in respect of all three children and criminal proceedings were instigated.

Child W’s Mother was arrested and subsequently cleared of any involvement in causing the injuries. Child W’s Father was convicted of a Section 20 assault (Offences against the Person Act 1861) and was sentenced to three years and nine months in prison.

Child W is now making progress. However, he is recorded as visually impaired and has left side weakness and an uncertain prognosis regarding his global development.

Adoption is being pursued in relation to all three children.

2. Purpose of the Serious Case Review and Terms of Reference

This Serious Case Review was commissioned in accordance with the Local Safeguarding Children Boards Regulations 2006 and Chapter 8 of Working Together to Safeguard Children (2006).

The purpose of this Serious Case Review was to establish what happened during work with this family to protect the children from harm, how far professionals from different agencies worked together and shared information and whether procedures were appropriately followed. The Review also sought to understand why professional intervention did not effectively protect Child W from harm. Conclusions and recommendations arising from the Review are based on lessons that should be learned from this case and are intended to improve practice and safeguarding arrangements so that similar risks of harm are avoided for other children. This should also reassure the public and prevent the need or demand for further external inquiries.

The Terms of Reference were in accordance with Chapter 8 of Working Together 2006.

3. The Independent Author of the Overview Report

The author of this overview report is Dr Carole Smith. She is an Honorary Senior Lecturer in the School of Nursing, Midwifery and Social Work at the University of Manchester. Between 1972 and 1994 she worked in the
voluntary and statutory sectors as a social work practitioner, team leader and senior manager in services for children and families, including responsibility for child protection. Her academic research, publications and teaching have concentrated on law, policy and practice in relation to statutory intervention with children and families, including issues associated with child protection and safeguarding. Carole Smith has no involvement with policy or practice matters relating to Rotherham LSCB or this case and is therefore able to take an independent view of the SCR process with regard to Child W.

4. **Agency Involvement and Reports**

The Serious Case Review Panel comprised representatives from:

- Rotherham MBC Children and Young People’s Services
- National Probation Service
- Rotherham Primary Care Trust (now ‘NHS Rotherham’)
- South Yorkshire Police
- Rotherham Foundation NHS Hospital Trust
- Rotherham MBC Neighbourhoods and Adult Services
- Rotherham, Doncaster and South Humber NHS Mental Health Foundation Trust.

Although the Independent Chair of RSCB was involved initially, chairing arrangements changed during the SCR to comply with changing guidance.

The Panel was advised by the Rotherham Safeguarding Board Manager and a Service Solicitor from Rotherham MBC.

To identify lessons to be learned from this case, the SCR Panel requested and received individual management reviews (IMRs) from the following agencies/services:

- Rotherham Children and Young People’s Services (Social Care)
- National Probation Service - South Yorkshire Area, Rotherham Division
- NHS Rotherham (formerly the Primary Care Trust)
- Rotherham Foundation Hospital Trust
- Rotherham, Doncaster and South Humber Mental Health NHS Foundation Trust
- South Yorkshire Police
- Rotherham MBC Neighbourhoods and Adult Services and 2010 Rotherham Ltd.

5. **Areas Considered by the Serious Case Review Panel**

Child W’s parents had themselves experienced poor parenting and involvement with social care services while they were living in another Local Authority and were thus already recognised as vulnerable parents when they moved to Rotherham. Information about their history included:

- allegations that Child W’s Mother had been sexually abused by a friend’s grandfather
concerns over possible links between Child W’s Mother and a registered sex offender
exclusion of Child W’s mother from school and the family’s homelessness
A health referral that Child W’s Mother was expecting her first child and “no parental skills are evident”
Referrals after Child W’s Father was excluded from school and concerns over his depression following the death of his father.
Further contacts with Child W’s Father followed a remand to Local Authority care after seriously assaulting his mother and subsequent allegations of assaults and threatening behaviour.

The family’s history from the time they moved to Rotherham in January 2004. Identified issues including:-

A second child was born in 2005
Allegations relating to domestic abuse involving Child W’s Father assaulting his mother (Child W’s parental grandmother) and his partner (Child W’s Mother)
Concerns about the home conditions and lack of accurate information about who was actually living with the Mother and her children
Difficulties in working with Child W’s Mother, who was frequently absent from her home address and missed pre-arranged appointments
Evidence that Child W’s Father responded to frustration and difficulties in his life through violent behaviour
Child W’s birth at his Father’s home (in poor conditions) when professionals were unaware that contact was taking place between the parents
Child protection procedures were not invoked despite Child W’s older siblings sustaining (relatively minor) injuries whilst subject to child protection plans.
Child W had prolonged severe nappy rash which can be an indicator of risk.

Professional intervention and assessment:-

Between September 2005 and October 2006 services to the family were managed under Child In Need Procedures. Social and Health Care professionals visited the family over this period, although this was sometimes difficult because Child W’s Mother was not at home for appointments and moved between her own home, her mother’s home and other accommodation. For much of the time Child W’s Father was not living at the family’s home address and there was a lack of accurate information about how much time he was spending with his partner and the children. Records indicate that several attempts were made to complete a core assessment, which would have identified the children’s needs, enabled an assessment of their parents’ capacity to meet their needs and informed an evaluation of risk with regard to the children’s development and potential harm. Frequent changes of social worker and health care professionals also made it difficult to engage with this family and to complete a core assessment. There is no
evidence that a core assessment was completed prior to Child W sustaining his injuries.

- Despite a recognition that that the children of this family were children ‘in need’, professionals were so concerned about completing the core assessment that they failed to provide any practical services which could have supported Child W’s Mother in her parenting and which might have helped her to engage more effectively with professionals. Services were not identified for this family until three children had been born and the situation was of such concern as to merit a child protection conference in October 2006.

- The Review identified issues associated with problematic management of the initial and review child protection conferences, which interfered with effective child protection planning.

- The review child protection conference lacked important information, particularly about Child W’s Father’s mental health difficulties and there was inadequate representation at the conference from agencies involved with this case.

- The fact that neither of Child W’s parents engaged fully with the assessment process and that they were frequently unavailable to professionals was not identified as a risk factor. However, professionals made little attempt to involve Child W’s Father in the assessment process. Additionally, it should be recognised that several factors, including changes in social workers and health care staff, militated against encouraging Child W’s parents to develop trust in professional workers.

- Professional fears about potential violence to staff from Child W’s father were not linked to the potential risk of violence to the children.

- There is evidence that (some) social workers ‘warmed’ to Child W’s Father because of his difficult history and evident vulnerability. However, professionals did not appear to have considered that this vulnerability might actually promote a risk of harm to his children.

- Poor communication between agencies and professionals during the period up to the initial child protection conference meant that health and social care practitioners did not have accurate and comprehensive information about Child W’s parents’ history and associated vulnerability and the Father’s history of offending and incidents involving domestic violence. This, together with the absence of a core assessment and risk analysis, had a detrimental impact on their ability to understand the family’s needs and the potential for harm to the children.
6. Key Learning Points

- Communication and information sharing between different agencies and within services must be improved to ensure that professional practitioners and their managers have a full picture of parental histories and a family’s current circumstances.

- Action must be taken to avoid discontinuity of workers and gaps in service provision, particularly as these problems contributed to a failure to complete a core assessment and associated risk analysis in this case.

- The management of Child Protection Conferences and agency representation needs to be improved to ensure informed decision making and effective child protection planning.

- Professional practitioners, particularly in children’s social care, must have appropriate training, opportunities for professional development and robust supervision to improve their ability to conduct a risk analysis and to challenge an overly optimistic attitude and low expectations towards parental capacity for change.

- Managers and professional practitioners, particularly in children’s social care, should be aware of the importance of understanding the impact of parental history on current parenting capacity and should, therefore, ensure that they obtain full information where parents have previously been known to another agency/local authority.

7. Recommendations

In addition to individual agencies progressing internal actions, the following recommendations were made by the Serious Case Review Panel and Rotherham Safeguarding Children’s Board:-

7.1 The Chair of RSCB should, by 30th September, 2009, advise agencies that where there are child protection concerns, verbal enquiries must be made of the Local Authority from which a family has transferred and the Operational Safeguarding Unit must be notified. Written confirmation of verbal information should follow, as should file access, within timescales required by assessments. (Progressing according to timescale).

7.2 The Chair of RSCB should, by 30th September, 2009, remind all agencies of the Safe and Well Protocol and require evidence that they have established systems to monitor compliance with the protocol. (Progressing according to timescale).

7.3 The Chair of RSCB should, by 31st August, 2009, remind all agencies of the requirement to ensure involved staff attend Child Protection Conferences and require the Operational Safeguarding Unit Manager, by 30th September, 2009, to establish systems to audit attendance and quoracy and report quarterly to RSCB. (Implemented).
7.4 The Chair of RSCB should, by 30th September, 2009, via the Strategic Safeguarding Manager, commission a joint protocol for managing risk in child protection cases where potential violence to staff is a feature. This must consider:

- Whether this constitutes a risk to household members
- How this is affecting professional intervention and how child protection planning can be maintained
- How the issue will be communicated effectively with partner agencies

(Progressing according to timescale).

7.5 The Chair of Rotherham Safeguarding Children Board should, by 30th September, 2009, commission a report from the Chair of the Learning and Development (Training) Sub-Committee to satisfy the Board that training around the indicators of risk, particularly the impact of domestic abuse on children and intra-familial violence, is available to all agencies (through development of the training strategy) over the next six months. (Implemented).

7.6 The Strategic Safeguarding Manager on behalf of the Board should, by the 30th September, 2009, remind all agencies of the procedures which explain the discontinuation of Schedule 1 Offender status and the steps to be followed if a person is considered to pose a risk to children. (Implemented).

7.7 The RSCB Chair will, by the 30th September, 2009, require Child Protection Conference Chairs to record in conference summaries any complaints about professionals made by parents or carers at meetings. (Implemented).

7.8 The RSCB Chair will, by 31st October, 2009, arrange a discussion between Rotherham SCB representatives from South Yorkshire Police and other agencies, particularly Children and Young People’s Services, in order to agree a process for ensuring that relevant agencies initiate direct communication where necessary, rather than relying only on procedural referral requirements.

7.9 The Director of Locality Services (in conjunction with Head of Children and Young People’s Services (Health)) must ensure, by 30th September, 2009, that there is a system in place to ensure that all children in need cases are reviewed in supervision on at least a three monthly basis. Case and supervision records should contain a written plan showing a clear analysis of need and focus of intervention endorsed by the Team Manager. (Progressing according to timescale).

7.10 The Director of Locality Services, by 30th September, 2009, should instruct staff to follow procedures in relation to initial and core assessments being conducted on a multi-agency basis. All agencies should prioritise access to current and previous files when a multi-
agency assessment is being completed. (Progressing according to timescale).

7.11 The Operational Safeguarding Unit Manager, by 30th September, 2009, will implement the standard of Child Protection Conference minutes being produced and distributed within one month of meetings and will report performance to the Board on a quarterly basis. (Implemented).

This Executive Summary was written by Steve Pearson, Communications Manager, Children and Young People’s Services, in consultation with Dr Carole Smith, Independent Overview Author

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