



**Gateshead
local safeguarding
children board**

Executive Summary of Serious Case Review

**CHILD D
2009**

1. BACKGROUND TO THE REPORT

- 1.1 In 2009, Child D, aged 17 months, was taken to hospital and found to have a healing un-displaced fracture to his right leg, bruising and his weight had fallen to below the second centile. He was a child who had been subject to a child protection plan and who had a care plan to protect against emotional abuse. The plan had been in place since October 2007. He had been living with members of his extended family since June 2008 when workers had decided it was too risky to leave Child D in the care of his mother.
- 1.2 Child D's weight loss had been a cause of concern since early January 2009. Further, on two occasions in January, professionals had seen marks and bruising on him. Unfortunately, at the end of January, a health professional who tried to investigate the situation, was denied the opportunity to see Child D.
- 1.3 It has been established in this review that for weeks, if not months prior to the date of admission, Child D was not receiving 'good enough' care within his extended family placement.
- 1.4 It is right in those circumstances that questions are asked about how it was that:
- (i) Child D suffered any harm in that placement
 - (ii) His deterioration went unrecognised by professionals
 - (iii) The build up of stress within the family, who had the care of Child D, went unnoticed
 - (iv) Requests for more support, made by that family, were not picked up or responded to adequately.
- 1.5 Gateshead Local Safeguarding Children Board (LSCB) determined that , in accordance with the guidance in Part 8 of *Working Together to Safeguard Children 2006*, it was appropriate to commission a serious case review to learn lessons from the case.
- 1.6 The following agencies were involved with the family of Child D and provide individual management review reports for the purpose of the review:
- Children, Families and Young Offenders Service, Gateshead Council
 - Gateshead PCT and Gateshead Health NHS Foundation Trust
 - Mulberry Bush Nursery
 - National Probation Service, Northumbria Area
 - Northumbria Police (Gateshead Area Command)
 - Safer Families Service, Gateshead Council
- 1.7 Gateshead LSCB ratified the overview report on 1 October 2009.

2. KEY FINDINGS

- 2.1 When Child D moved to the care of a couple in his extended family, the risks inherent in that placement, were for a long time, known only to the workers in Children's Services. Information about the male carer was not shared and a multi-agency risk assessment was not undertaken. Moreover when, in late November, that male was arrested and further concerning information came to light the workers failed to re-assess the risk.
- 2.2 Initially the placement appeared to be successful and Child D did well.
- 2.3 However by the end of November and beginning of December 2008, the indications were less positive. Individual workers in many of the agencies were presented with information, which ought to have prompted a re-appraisal and by January, workers should have been considering removal.
- 2.4 Individual workers are criticised in the body of the report for failing:
- (i) To share information
 - (ii) To recognise that Child D and the family were in trouble and
 - (iii) To respond promptly.
- 2.5 With the exception of the Nursery, which has already accepted that it needs to alter its policies in relation to referrals, recording and reporting injuries and absenteeism, all other agencies have policies in place, which are conducive to "working together".
- 2.6 The policy change recommended, which relates to disclosure by Northumbria Police, addresses an anomaly highlighted in this review process, which did not in fact have any impact in this case.
- 2.7 In June 2009 the couple, who cared for Child D, his maternal aunt and her partner, accepted in each case an adult caution for committing an act of cruelty to a child under the age of 16 years in that they failed to provide Child D with sufficiently nourishing food.
- 2.8 Child D is believed to have suffered no lasting physical damage.

3. REPORT CONCLUSION

- 3.1 There is evidence of sub-optimal working of the case by individual workers, predominately in Children's Services but also in Health, Nursery and the Police. Although some system or policy changes are recommended, the principal problems in the case arise out of failings on the part of individual workers.

4. OVERVIEW REPORT RECOMMENDATIONS

- 4.1 Safer Families should prepare a closing summary and updated risk assessment to be shared with all referring agencies when a perpetrator completes/does not complete a Violence Prevention Programme.

- 4.2 Northumbria Police should act to eradicate the difference that exists between the information that can be accessed by the Disclosure Unit and the local Child Abuse Investigation Units. It is noted that the author of the Police Individual Management Review report recommends that the Disclosure Unit should have access to Impact Nominal Index.
- 4.3 Whilst a difference remains in the scope of information to be obtained and the speed of access to that information, depending upon which approach social workers make to the Police for information, the merits of each approach should be clarified to professionals and further training and liaison between the two agencies should be organised.
- 4.4 The policy of Gateshead Children's Services was to assess formally this family placement even though meeting the requirements of foster regulations was not necessary. Given that all involved with Child D at the time had a duty to safeguard him and ensure his best interests were met, it is difficult to see how the policy could be anything other. It was not the policy that was at fault but rather the implementation of it by social workers and the management of those social workers. I am therefore not convinced that a full review of the arrangements and procedures surrounding family placements is targeting the right issue. Working practices were at fault; training is more pertinent.
- 4.5 It is noted that Gateshead proposes to make an approach to the Department for Children, Schools and Families for guidance on the status of informal family placements and the local authority's role in supporting them. Whilst such an approach is not positively recommended to the review panel as it addresses something that has not been identified as a problem in this case, it may help in other situations.
- 4.6 The Nursery has already implemented a policy change, which this report would have recommended, namely that no child, subject to Child Protection Plan, is accepted without clear written details of the basis upon which the referral is made. If the Nursery is charged with the task of monitoring and protecting risk then it needs to know exactly what are the anticipated risks and how those risks can be managed. There should be a clear definition of how workers discharge their obligations to monitor, record and report. It has already been acknowledged by the Nursery that accurate records of injuries and attendance must be kept and prompt notification given to the referrer of any injuries not known to be accidental and any absenteeism.
- 4.7 The need for Health workers to be prompt in their response to suggestions that a child who is subject to a Child Protection Plan may have weight or health difficulties has been acknowledged in that agency's report. The need to recognise the significance of missed appointments as a sign that "all may not be well" has also been acknowledged. The importance of being denied an opportunity to see a reportedly sick child needs to be stressed and the need to see a child more than was the case here appears to have been conceded. Health workers must be alive to signs of abuse and ready to take prompt action.

- 4.8 The recommendation made in the Health agency's Individual Management Review report that written agreements should be drawn up ought not to be adopted. It is the task of the conference to draw up an effective child protection plan and that should include a clear statement of risk, how it is to be managed and by whom. The detail of what exactly is expected of each professional and family member should be set out clearly in the plan. Merely adding another layer of bureaucracy does will not assist and is not recommended.
- 4.9 At the heart of what went wrong for Child D was the failure to disclose at the outset the risks inherent in a placement with AM. At the very least such disclosure would have caused all agencies and professionals to be more vigilant. It is reasonable to suppose that closer monitoring would have led to Child D's plight being discovered sooner, it should also have led to the realisation that the placement was no longer safe. This was primarily a failing on the part of Children's Services, which was compounded by others and never corrected. Finally, key workers had information in the weeks leading up to Child D's admission to hospital which should have prompted a reassessment of risk; those individuals did not act quickly in response to the signs which suggested the placement was failing and may have been no longer suitable. All the professionals implicated in the failings identified in this report to learn from this experience, redouble their efforts and remain vigilant.