WIGAN
SAFEGUARDING CHILDREN BOARD

SERIOUS CASE REVIEW

CHILD A

APRIL 2008

1. Introduction

This report summarises the findings from a Serious Case Review that was held in order to consider how effectively agencies had worked together to safeguard Child A.

The Review established the facts and analysed the practice of the professional activity to undertaken protect and promote the welfare of Child A.

The Review was conducted in accordance with the Working Together to Safeguard Children guidance issued by the Department for Education and Skills in 2006.

2. Membership of the Review Panel

The Review as overseen by a Serious Case Review Panel, which included representatives of Wigan Children and Young People's service – Youth Offending Team, Children's Social care, Performance Planning and Quality Assurance, Connexions and Education Welfare; Greater Manchester Police; Wrigtington Leigh and Wigan NHS Trust; Ashton Wigan and Leigh PCT, alongside a representative from Wigan Legal services and an Independent Social Worker who wrote the full Overview Report.

2. The terms of reference for the Review

The general Terms of Reference are as follows:

- To establish the facts of the case in relation to each individual agency.
- To consider individual agency and multi-agency decision making in respect of Child A and her parents and any actions taken or not taken; with specific emphasis upon risk management and the impact of domestic violence.
- To commission an independent person with appropriate experience to produce an overview report.
- To review all relevant records relating to Child A and her parents from November 2005 to September 2007 from the following Agencies:
  Police
  YOT
  Education
  Wigan Children and Young People's Service
  Health, Trust and PCT
  Wigan Council Legal services
- To invite the parents of Child A to contribute to the review.
- To establish a clear action plan for individual agency implementation.
- To provide a multi agency overview report in accordance with the guidance contained in Working Together to Safeguard Children.
- To develop a multi agency action plan arising from the issues identified by the overview report.
- To provide an Executive Summary.
- To undertake the above actions by end April 2008

3. Contributions to the review

3.1 The following contributions were provided and considered from professional sources:

- Wigan Children's Social Care, Management Review and Chronology
- Wigan Performance, Panning and Quality Assurance, Management Review and Chronology
- Wigan Youth Offending Team, Management Review and Chronology
- Wigan Connexions and Education Welfare Service, Management Review and Chronology
- Greater Manchester Police, Management Review and Chronology
- Wrigtington Leigh and Wigan NHS Trust, Chronology
- Ashton Wigan and Leigh PCT, Management Review and Chronology

3.2 The parents of Child A were both invited to contribute information but did not do so.

3.3 Each agency provided a detailed and critical analysis of their performance and identified areas where practice could be improved as a consequence of the learning from this case.

4. Brief Summary of Events

4.1 At approximately 5 months old, Child A was discovered to have a serious physical injury which medical evidence concluded could not have happened accidentally.

4.2 As the child had been subject to multi agency and child protection procedures from birth, a decision was made by Wigan Safeguarding Children Board and demonstrates the Board's to convene a Serious Case Review as a commitment to facilitating learning and identifying any actions that will assist the safeguarding of children in Wigan in the future.

4.3 The child's Mother and extended family were known to agencies providing universal and more targeted child care support and protection over a period of many years. As such, all agencies were aware of the child's needs for protection prior to her birth.

4.4 The specific concerns for the child's welfare related predominantly to the potential for domestic violence between the parents and various members of the extended family, alongside the need for general support to the young first time parents.

4.5 The various agencies sought to support the parents in the care of the child, although in hindsight, it is clear that assessments of their circumstances and ability to engage with Agencies can be described as over optimistic.

4.6 There were a number of occasions where significant information which impacted upon the risks to the child was not fully considered or analysed and therefore the child's plan for protection was not amended in accordance with changing risk factors.

4.7 It was noted that the time frame for the review, represented a period of time when there was an acute shortage of social work staff, and consequent greater reliance on Agency staff which resulted in a number of changes to the case management.

4.8 Overall the review identified a number of practice learning points for assessment, case management and quality assurance.

5. Identified Areas for Learning and Good Practice.

The following recommendations reflect the areas for learning identified by the relevant agency:

5.1 Children's Social Care:

- Where a parent is also a child, their needs must be considered separately to those of their baby. A core assessment and plan must be in place in respect to how these needs can be met.
- Although ICS will result in the compiling of more cogent electronic information, action needs to be taken now to improve the structure of child protection files. The files must contain a through and up to date chronology and a section devoted to child protection that is listed in chronological order. This will be subject to audit both within supervision and at the child protection review when an updated chronology should be presented to allow all agencies to add to it as necessary and satisfy all parties that all known information is recorded and acted upon.
- Social workers must satisfy themselves at each visit that the address given is the current one and ensure any changes are noted on electronic systems and the file.
- Child Protection visits should be recorded separately to diary sheet entries and address with the parents and child, as appropriate, the plan and progress against this. Team Managers will countersign these visit reports at each supervision session.
- Where cases are unallocated even for a few days, team managers must ensure that core groups and conferences are attended.
- When of necessity there are multiple workers then management oversight is even more important. A protocol to be developed to ensure that if there is a need to re-allocate beyond the usual transfer between Duty and CIN Teams, then the transferring Manager will meet with the receiving Manager to ensure the whole case is discussed. This discussion and any decisions resulting from it will be recorded on file and discussed by the receiving Manager with the allocated social worker.
- Plans to be made to progress as early as is practicable the processing of all domestic violence information by Duty.

5.2 Performance, Planning and Review

This service has line management responsibility for Independent Reviewing Officers.

- Copies of Core Assessments, Action Plan and Core Group Minutes must be made available to Conference.
- Child Protection Plans should be SMARTER and if plans are not completed in a timely way, a protocol needs to be agreed as to how this can be addressed.
- A clearer protocol needs to be established between the Chairs of conference and the social workers management teams to address issues of concern.
- Where this is another family involved in the child protection process whose progress impacts on a child/children, the same Chair will be used wherever possible to promote consistency and to enable more effective information sharing.

5.3 Youth Offending Team

- Concerns regarding the management of a case, must be addressed to the manager of the social work team

5.4 PCT

- For family Health visitors to attend Case Conferences where there is a known pregnant subject.
- To review supervision within Health Care for practitioners working with highly complex family dynamics and vulnerable children.
- To consider methods of managers in health and social care sharing concerns about high risk families.

Neither Greater Manchester Police nor The Connexions and Education Welfare Service identified any specific areas for practice improvements, which was considered appropriate by the Review Panel.

5.6 The Review Panel highlighted **good practice** in the YOT service. This service was noted to have provided a higher level of contact than required by National Standards in recognition of the complex and particular needs of their service user.

6. Recommendations made by the Serious Case Review

The Case Review adopts and accepts the individual Agency recommendations, and makes further overarching recommendations as follows:

- Wigan is currently developing an inter agency protocol with regard to domestic violence, and it is recommended that this case review is used as an instructive case scenario to develop best practice.
- That Wigan Safeguarding Children Board should ensure practice guidance is developed to assist practitioners in the management of cases where domestic violence is a feature.
- That a meeting which plans the discharge of a child from hospital about whom there are child protection concerns is chaired by a Group Manager or above.
- Wigan CYPS has recently arranged training with regard to Core Groups, it is recommended that specific training is also in place for social workers who are case managers.
- Wigan has recently agreed a communication protocol between Independent Reviewing Officers and case work operational managers; it is recommended that this should be disseminated to all staff.
- That Wigan Children's Social Care undertake an immediate review of children placed on the Child Protection Register to ensure that every child's plan is adequate to promote his/her protection.

The Review Panel noted that progress in respect of many of the recommendations was achieved or in progress during the period of the Serious Case Review.