Serious Case Review

Executive Summary

In respect of Baby Z

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INTRODUCTION

1. This executive summary of a serious case review examines the circumstances leading to Baby Z, a six month old child sustaining serious injuries whilst in the care of the local authority.

2. There was a significant delay in the reporting of key medical test results which led to delayed treatment and the police investigation commencing. The re-consideration process conducted between July and September 2009 following the Ofsted evaluation of the review highlighted delays in a number of stages in this case; the delay in reporting the medical results being the most serious in terms of affecting the child's safety and health.

3. The serious case review was commissioned in line with government guidance contained in Chapter 8, Working Together to Safeguard Children (2006).

SERIOUS CASE REVIEW PROCESS

4. The first meeting in April 2008 of the Serious Case Review Panel confirmed the scope and terms of reference for the review. Particular emphasis was given on addressing the quality of communication between services. Individual management reviews were commissioned from;

    - Children's Social Care Services Blackburn with Darwen Borough Council
    - Primary Care Trust (PCT) Blackburn with Darwen
    - Lancashire Police
    - Legal Department, Blackburn with Darwen Borough Council.
    - Children and Family Court Advisory and Support Service (CAFCASS)
    - Early Years Excellence (EYE), Blackburn with Darwen Borough Council

5. The parents were not involved in the review process. The Local Safeguarding of Children Board (LSCB) met with Baby Z's father and foster mother (foster carer at the time of the injuries) to discuss the findings of the serious case review and Ofsted's evaluation in July 2009. Baby Z's mother did not contact the LSCB to arrange a meeting, and the foster father was unavailable at the meeting in July 2009.

6. Ofsted evaluated the serious case review as 'inadequate' in May 2009. The LSCB met with Ofsted Inspectors in July 2009 and agreed that a re-consideration report would address the areas of inadequacy. The serious case review panel met again in August 2009 chaired by an independent author, who produced the re-consideration report submitted to Ofsted in October 2009.

7. In December 2009 Ofsted wrote back to the LSCB having evaluated the re-consideration report as satisfactorily addressing the inadequacies identified in their May 2009 evaluation.

8. This executive summary reflects all the information presented to the LSCB from the original review and the re-consideration process.

SUMMARY OF EVENTS DETAILED IN THE OVERVIEW REPORT

9. Blackburn Children's Services have been involved with Baby Z and parents since birth in August 2007. Prior to birth, information was received from the local authority where the mother lived prior to her move to Blackburn. This information suggested that Baby Z's mother had experienced significant trauma in her life, including domestic abuse, which could compromise her ability to parent Baby Z. An initial assessment was undertaken by the Referral & Assessment Team, and was completed in a timely manner concluding that Baby Z's mother would benefit from "low level support". There was good information-sharing between three different children's services. However, the analysis of information was not sufficiently rigorous leading to an overly-optimistic conclusion that only lower level support was required.

10. In September 2007, children's services received a request from Baby Z's mother for her baby to be removed from her care and placed for adoption. Baby Z's father did not agree to this request but at that time was unable to care for Baby Z himself. Baby Z was accommodated for five days before returning to mother's care at her request.

11. During the short period when Baby Z was back in the care of the mother, concerns suggested she was finding it difficult to care for Baby Z. A home visit in mid October 2007 was made by the Health Visitor. Baby Z's mother was seen to have a black eye, allegedly the result of domestic abuse. Although this was reported to the social worker, no follow-up visits were made by either the health visitor or social worker, nor was the matter reported to the police. Throughout children's services contact with the mother in the period September to October 2007, she alleged violence, intimidation and coercion from Baby Z's father. Children's services' chronology for this serious case review shows that staff only advised mother once on how to seek help.

12. A referral was made to a local children's centre to offer support to Baby Z's mother and to establish the parents' capacity to care for Baby Z. A planning meeting was arranged in October 2007 and plans where made to begin core assessment sessions using children's centre staff in November 2007 – some six weeks after Baby Z had returned to mother's care. The core assessment though initiated in November 2007 was not complete until February 2008, significantly outside of the national standard of 35 working days.

13. At the end of October 2007, Baby Z was placed with foster carers. Mother stated she could no longer care for the baby due to domestic violence and left the child with children's services staff. Baby Z was placed with the original foster carer and contact arrangements were made with the birth parents. Mother maintained contact in this early period; however father did not; his family were not aware of his partner, or the birth of a child with this partner.

14. In the period after Baby Z was taken into care a second time, father informed his family of his child with a view to exploring if any of his family or friends could foster the child. Placement Services initiated the process to assess members of the father's family. During this period the Family Court directed that a child's guardian be appointed but this was not communicated to CAFCASS until a month afterwards.

15. Baby Z was made the subject of an Interim Care Order and placed in foster care. Baby Z's father requested a placement that would meet the child's cultural needs. In February 2008, Baby Z's foster carers were changed to meet the wishes of the father. This foster placement had not been available when Baby Z was initially placed in care at the end of October 2007. Contact was maintained for Baby Z; father's family now aware of the child attended most of the contact sessions, whereas mother's visits waned.

16. Baby Z was examined under the LSCB procedures in hospital on two occasions in February 2008, whilst in the new foster placement. On the first occasion, the cause of the injury was considered to be accidental and consistent with the explanation given by the foster carer. These results were verbally communicated on the day, but took three weeks to report back in writing to social workers.

17. The second injury was reported by the foster carer and then noted on the same day when Baby Z attended a routine Looked After Child (LAC) medical review. The examining doctor noted "unusual "abrasions" on the face and body. The foster carer could provide no history for these abrasions. The doctor referred Baby Z to the consultant paediatrician at the hospital for further examination.

18. Baby Z was examined by the consultant paediatrician who followed LSCB and Trust procedures, and requested a full skeletal survey as well as dermatological tests to ascertain if there was a medical reason to explain the cause for the abrasions.

19. Baby Z was discharged from hospital the next day into the care of the original foster carers from September 2007. This was a precautionary measure as there had been no clear explanation as to the cause of the injuries sustained whilst in the current placement. Child protection procedures were appropriately followed, and a first strategy meeting was held. However, the results of the medical tests were not available for that meeting and therefore it was decided that there would be no police investigation until the outcome of these tests were known and the meeting was re-convened. There was no health representation at the strategy meetings; this was a significant oversight given the medical results form the dermatological tests were available at this point.

20. There was a significant delay in communicating the results of the medical tests. Whilst the dermatological tests results were received a week later, the results of the skeletal survey where not communicated to the paediatrician until three weeks after the x-rays had been undertaken. The results of the skeletal survey revealed Baby Z had fractures to one arm. Therefore, Baby Z did not receive the appropriate medical treatment required at the time and an investigation of significant harm was delayed.

FOSTER PLACEMENT

21. The foster carers looking after Baby Z at the time the injuries were sustained were approved in March, 2007. Although the fostering panel recommended their approval they noted the lack of analysis contained in the social worker's report; however it was felt sufficient information was provided to support a recommendation for approval as foster carers. In hindsight it is apparent that information from the training and preparation sessions during the assessment and pre – approval process should have been subjected to closer examination and analysis; for example the foster father was not always present, and did not fully participate in the training due to language difficulties.

22. The foster carers had a first child placed with them in April 2007. This was recorded as a successful first placement for both of them and the child they fostered. During this placement there had been a reported incident to the police of a disturbance at the family home in July, 2007, resulting in an abandoned 999 call being made to the police. This matter was investigated by children's services and it was considered to have involved relatives of the couple, not the couple themselves. The foster carers were informed that such behaviour would not be tolerated due to the impact it had on children.

23. At the initial review of the fostering panel in January 2008, a further period of registration was agreed. At the end of January 2008, the first child they were looking after had a successful transition to a new placement.

24. Baby Z was placed with the foster carers in February 2008.

KEY THEMES AND LESSONS LEARNT

25. Children's services tried to support Baby Z's mother prior to applying child protection procedures. The parents' wishes to have their baby accommodated with foster carers who could better reflect their own cultural and religious needs were pursued; contact was maintained between Baby Z and parents; extended family were considered as possible carers for Baby Z.

26. The LSCB procedures were appropriately applied in this case by the agencies involved.

27. A key learning point is that the quality of assessment and analysis of information in the assessment needed to be more rigorous; this needed a clearer application of theoretical knowledge to examine that information, leading to a clearer plan for intervention from the outset of work. The lack of analysis was evident for the initial assessment, the organisation of support to the family and the assessment, preparation and approval of foster carers.

28. Linked to the quality of assessment is the need for professionals in particular to be alert to indicators of domestic abuse including emotional coercion, and to understand the implications for understanding and managing risk to the emotional and physical care of children.

INITIAL ASSESSMENT AND FAMILY SUPPORT

29. Core Assessments should have been undertaken at two significant points; firstly following the initial assessment (August 2007), where the process could have assisted with determining the ability of mother to provide care for Baby Z; and secondly at the point where Baby Z was returned to the mother's care after being placed in foster care for five days in September 2007. At this point the agencies involved had been able to observe how the parents were coping with providing appropriate care for Baby Z. A Core Assessment and child protection strategy meeting would have afforded the opportunity to examine mother's history, assess the impact of domestic abuse within the family, and gather relevant information about father's history, of which too little was known at that stage. Apart from consulting the father at crisis points, he was not actively engaged by agencies in the assessment or planning processes.

30. In all assessment and planning processes it is vital that every agency involved in the care and welfare of the particular child should be invited

and involved equally, bringing to the processes all available information of families, sharing this information within and between disciplines, and co-ordinating and progressing the various services in place to safeguard children. Delays in sharing and processing information are evident in this case for all agencies involved.

FAMILY PLACEMENT

31. As a point of good practice, the social worker who completed the foster carer's assessment was of the same culture and religion. However, the training provided to the foster carers had not considered the language difficulties of the foster father, and the social worker involved with the case during Baby Z's placement was not from the same cultural background; this presented difficulties in communication with the foster carers.

32. A further report should have been requested by the fostering panel in light of the social worker's report lacking sufficient analysis.

33. It was noted that the foster father was not available for some of the planned sessions.

34. It was essential for both foster carers to be fully and equally involved with the assessment process. Therefore, alternative dates should have been arranged for him to attend and complete the assessment process.

HEALTH

35. Between the various disciplines within health there were a number of opportunities when information sharing could have been better: between maternity services and the health visitor; between the health visitor and GP; between the radiologist and paediatrician; and between the health visitor and paediatrician. Whilst each discipline followed child protection procedures rigorously, they did so within the limits and structures of their own discipline and not between the different health disciplines, or effectively enough with other external agencies.

36. The delay in communicating key medical test results between the radiologist and the paediatrician as a result of record keeping and systems failure, led to delays in treatment being received by Baby Z, in initiating child protection procedures for Baby Z, and with the subsequent police investigation. The consideration of a child protection strategy meeting with regard to the foster carer's birth child was also delayed.

RECOMMENDATIONS

Introduction

37. The serious case review panel endorse the recommendations contained in the management reports from the agencies involved. The recommendations which are detailed below have significance for all agencies, even where they are addressed to specific agencies. A detailed action plan has been developed to support the implementation of the recommended improvements.

38. Blackburn with Darwen LSCB will monitor the implementation of the actions from the recommendations, reporting their progress to the LSCB, and local strategic partnership (LSP) through the Children and Young People's Trust. The Strategic Director of Children's Services will report to elected members through the relevant Executive Committees.

Children's Services (Social Care)

1. Training regarding analysis and risk in assessment should take place for all social workers in Referral and Assessment to include the importance of historical chronologies.

2. Team managers in Referral and Assessment should have a mechanism for reviewing the plans set in place following the initial assessment through the caseload tracking and monitoring systems and review panels within the service.

3. The principal social worker (for staff development), within the Referral and Assessment Team should review the operation of the Continuum of Need and Response Framework within the team with a focus on cases which are borderline level 4/5.

4. The Referral and Assessment team should develop a plan to facilitate improved engagement of fathers during initial assessment and in child in need cases.

5. The department's contact procedures should be reviewed to ensure that they consider risks associated with domestic abuse.

6. A review of current arrangements to plan for placement moves of children in care should take place with a view to developing practice guidance based on best practice regarding introduction plans and placement moves for looked after children.

7. A reminder should be issued to all family support social workers that where one child residing within a household becomes subject to a Section 47 investigation, immediate consideration should be given to any other child in the household in line with LSCB procedures.

8. A procedure should be developed jointly with pediatricians in respect of results remain outstanding when children are discharged from hospital with suspected non-accidental injuries; and which should include their attendance at strategy meetings.

Children's Services (Placement Services)

1. Training on analysis to be provided to Fostering Team.

2. Allocation of cases should take into account potential language barriers and the need to allocate to people who can communicate in the applicant's first language wherever possible.

3. Pre and post approval training will be presented with the assistance of an interpreter where any prospective or existing foster carers are not proficient in English.

4. The Head of Service will share this report with the fostering panel and the areas highlighted with the fostering team to ensure that the lessons are learned.

Children's Services (Early Years)

1. All recording functions for children's centres to be reviewed and the file audit process revisited with all managers.

2. To review the request with social care colleagues for service process and level of detail required to inform sound decision making and effective service planning.

Health

1. East Lancs Hospital's NHS Trust and NHS BwD to have systems in place to respond to pregnant women and/or mother's suffering domestic abuse.

2. Examining paediatricians will liaise directly with radiologists when a request is made for a full skeletal survey, clearly explaining the reasons for the request and the need to consider non-accidental injury

3. Radiologists will report on the findings of any x-rays with the examining paediatrician present if possible, and will convey the results both verbally and in writing as soon as possible.

4. A health professional to be seconded to the Children's social care referral and assessment team, to promote the inclusion of health information into initial and core assessments, and s.47 enquiries.

5. East Lancs Hospital's Trust to review their processes for sharing information/ liaising with community health colleagues i.e Health Visitor and GP when concerns regarding the unborn baby/ baby and their family have been identified.

6. BwD LSCB to review policy and procedures relating to invitation of health professionals to multi-agency strategy and planning meetings, and child protection conferences.

Legal Services

1. Legal Services role within the Serious Case Review process needs some clarity. Greater scrutiny needs to be applied when determining the terms of references so as to give clarity to:

    - when Legal Services are required to prepare an Individual Management Report (IMR) and what value the production of such a report can contribute; and/or
    - when the role of Legal Services is limited solely to the provision of legal advice to the Serious Case Review Panel.

2. When the subject(s) of a serious case review is/are also the subjects of ongoing court proceedings, there should not be an automatic assumption that the provision of an IMR will be necessary. In some instances, such as in this case, the care proceedings may be in existence to address much wider issues which are not always relevant to the serious case review process. Where terms of reference include periods when care proceedings were ongoing, the Deputy Head of Legal Services or the Senior Solicitor will determine with a SCR Panel when an IMR will be necessary.

CAFCASS

1. Managers to review all files to ensure compliance with CAFCASS recording policy.

2. The Office Manager and the Service Manager to ensure other staff also comply with CAFCASS recording policy.

3. A cross reference to be put on the paper file when electronic documents are in use. This would help clarify the case plan and the work undertaken. Changes will be evaluated via file audits.

Multi-agency recommendations to Blackburn with Darwen Local Safeguarding Children Board

1. Individual agencies to remind staff that when service-users report that they are suffering domestic abuse, it is followed up to ensure the alleged victims are supported and to consider what actions may be required to safeguard and protect any children present within the home, as well as the alleged victim.

2. Managers in health and children's services should review the health practitioner's role in the core assessment process and ensure procedures and training supports coordinated practice.

3. All agencies to consider the value of verbal as well as written invitations to meetings which plan and co-ordinate services to children and their families. This would help to ensure the attendance of professionals and agencies that have a significant contribution to make to the case.

4. Share the completed executive report with parents.

5. Develop a LSCB communications strategy to include communication requirements during the process of conducting serious case reviews.