FOR PUBLICATION

Rotherham Safeguarding Children Board

Executive Summary of the Overview Report of a Serious Case Review in respect of AX, BX and CX completed by Judith Dodd, Independent Consultant, on behalf of Rotherham Safeguarding Children Board

1. Circumstances of the Review

A Serious Case Review was commissioned by Rotherham Safeguarding Children Board (RSCB) on 4 October 2006 following the death of a child (CX) whose name, along with those of his two sisters, had been on the Child Protection Register in the category of neglect, since April 2006.

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

Serious Case Reviews should always be conducted when a child dies and abuse or neglect is known or suspected to be a factor in the death.

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

The Serious Case Review Panel was made up of representatives from RMBC, Rotherham PCT, South Yorkshire Police, Connexions South Yorkshire, 2010 Rotherham, Probation Service, Rotherham General Hospital Foundation Trust, Sure Start and RCSB.

The Review considered whether there were lessons to be learned from this case about the way in which professionals and organisations worked together to safeguard and promote the welfare of CX and his sisters AX and BX between January 2002 and August 2006.

It identified what those lessons were, what actions would be taken and what changes were required in order to improve inter-agency working. Key issues and concerns have been identified with a view to supporting best practice in the future.

3. The Independent Author of the Overview Report

Judith Dodd has extensive experience in social care having worked as a social work practitioner, Guardian ad Litem, Adoption Panel Chair and as a Team, Service and Senior Manager in Social Care. She has a Diploma in Social Work, Diploma in Higher Education and an NVQ5 in Operational Management. Judith Dodd now undertakes consultancy work on an independent basis.

Ms. Dodd completed her report in March 2007 and subsequently became the independent Chair of the Board. Joyce Thacker, Senior Director of Children and Young People's Services, chaired subsequent Serious Case Review Panel meetings and agreed final amendments in June 2007.

4. Agency Involvement and Reports

Individual management reviews were completed by:

- Rotherham MBC Children and Young People's Services (Social Care and Inclusion, Voice and Influence) and Schools
- South Yorkshire Police
- Health Management Review on behalf of Rotherham Primary Care Trust, Rotherham Foundation Hospital Trust, Doncaster & South Humber Health Care NHS Trust
- National Probation Service (South Yorkshire)
- Surestart Children's Centre
- Neighbourhood and Adult Services and 2010 Rotherham Limited
- Connexions Nord Anglia Lifetime Development
- Rotherham Youth Offending Service

The family declined invitations to be involved in the Review.

5. The family involved comprised of:-

Children:

AX	Female	born in 1990	
BX	Female	born in 1992	
CX	Male	born in 2003	Died 26.08.06
DX	Mother	born in 1972	
FO	Father to AX and BX	born in 1972	
DT	Father to CX	born in 1971	
YY	Partner to DX	between 1999 and 2002	

All family members are white British.

6. Summary of the case

In August 2006 child CX was involved in a road traffic collision with a car outside the family home and died in hospital the following day from the injuries he sustained. He was in the care of his sister (BX) at the time of the incident.

DX was a single parent who, at the time of CX's death, lived with her three children in a council owned property. The family lived at four addresses between 1992 and 1996 when DX separated from the girls' father.

There were no identified concerns about the family prior to 2002. From April 2002 to April 2006, however, there were a number of referrals from various agencies to Social Care relating to the family. The referred concerns included the following:

- Substance and alcohol abuse
- Persistent non-attendance at school
- Criminal damage and anti-social behaviour
- Concerns about CX's development
- Family being in crisis with DX being unable to exercise her parental responsibility.

In April 2006 following issues relating to aggression in the home and its impact on CX, a child protection conference was held and all three children were placed on the Child Protection Register in the category of neglect. A review conference in July 2006 agreed that protection concerns had heightened. No written child protection plans were produced by the core group and a second review conference was set for December 2006.

7. Key Learning Points

This case has highlighted the following:-

- The need for thorough multi-agency assessments to inform safe and effective planning based on a multi-agency package of support and intervention.
- The need for co-ordinated delivery of service with regular monitoring of case progress.
- The need for accurate and clear information sharing at key stages.
- The need to have clear and timely case recording.

8. Good Practice

The Review noted evidence of good practice in:

- The persistence of the Family Support Worker who found planned work with the family very difficult given the chaotic home conditions.
- The health visitor identified CX's health needs and the impact upon him of living in a violent household.
- Substance Misuse Services successfully met with child AX twice in 2005; unfortunately further attempts to re-engage her were unsuccessful.
- Child In Need meetings held in February and March 2006 were well attended and considered relevant issues. However, these should have taken place earlier and there should have been more focused planning

9. Areas for Improvement

This case has highlighted issues and areas for improvement under the following headings:

Prevention and Early intervention

- This case has highlighted the importance of early intervention at the first sign of a child or family experiencing difficulties.
- Workers should consider, and be pro-active in making, referrals to substance and alcohol services about children for whom they have identified concerns
- Workers should listen to children who voice concerns about bullying and respond appropriately

Adherence to Child Protection Procedures, Risk Assessment and Protection Planning

- This review demonstrated the need for compliance with existing procedures, effective practice and good management and decision-making.

Referral & Information Sharing

- Where a referral is made about a number of children in a household, all their details should be entered and the referrals should be cross-referenced on the CYPS client information system
- Where professionals see children with unexplained injuries, they must pass this information on to the allocated social worker or health visitor.
- South Yorkshire Police should follow up abandoned calls and request officers to attend to clarify the circumstances in line with policy.
- Neighbourhood and Adult Services will inform Social Care when taking action against a household with children

Enquiries to the Child Protection Register/ List of children with a child protection plan

- A second child protection register check in 2 years should trigger an initial assessment which provides an opportunity to consider a family's circumstances.

Assessments and Recording

- Workers must make contact with a family before a referral which has progressed to initial assessment is closed

Child Protection Planning

- All child protection conferences must focus on the levels of risk to children, direct appropriate agency action to secure children's well-being promptly and without delay.

Visits to Children on the Register/with a child protection plan

- All children with a child protection plan must be visited every two weeks by a social worker.

Thresholds and Risk Assessment

- Team Managers in Social Care must apply appropriate thresholds for action.
- Workers in all agencies should discuss, and where necessary challenge, decisions which they do not believe reflects the risk identified for a child.

Alcohol and Substance Misuse by young children

- Referrals to Social Care and specialist substance misuse services must be made where children attend Accident and Emergency under the influence of alcohol or drugs.

Agency responses to persistent non-co-operation by Parents

- Where parents or carers do not co-operate, agencies must be vigilant and work together to implement a clear plan to protect children.

Appropriate Supervision of Children

- Personnel involved in Truancy Patrols should assess the impact of inappropriate child care arrangements, including any child protection issues, on their safety and well-being. Where required, enquiries should be made of the Safeguarding Unit to check the list of children subject to a Protection Plan.

Non-School Attendance

- A holistic multi-agency response is required to effect change where non-school attendance is part of a broad range of problems experienced by a family.

Safeguarding issues for adults with mental health problems

- Adult mental Health Services and GP practices should routinely record details of patients' responsibilities in relation to children and take appropriate action where potential risks are identified.

Working with (absent) Fathers

- It is essential that fathers and male carers are involved as fully as possible in assessments. Probation and Health Services should make detailed enquiries about adults' personal circumstances and any involvement with children.

Assessment of Extended Family

- Where children who are subject to a protection plan move in with relatives, or move out of the family home, agencies should explore and assess the support provided and the appropriateness of care arrangements.

Working with deteriorating and violent relationships within families

- Where the Police assess a person under sixteen years old as being the aggressor in a family situation, Social Care should be advised

Resolving professional differences/ Problem resolution

- If referrers to Social Care do not receive a response, this should be followed up via line management processes

- Where there is a difference of opinion between staff/agencies about decisions on a child protection case, this should be challenged and, if necessary, raised with line managers or the Safeguarding Unit in line with Rotherham's Safe and Well Practice Guidance.

Recording

- Written child in need or child protection plans and minutes of core group and child in need meetings must be produced and placed on children's records

- File audits by managers are essential to highlight any compliance issues.

- Improved recording practice needs to be embedded in the Education Welfare Service in respect of Truancy patrols and in Neighbourhood and Adult Services in relation to events leading to Acceptable Behaviour Contracts.

Supervision and Training

- This review has identified that several of the staff involved require training in child protection and a greater understanding of the requirement for a multi-agency approach to safeguarding.

10. Recommendations

The Safeguarding Children Board, through the Serious Case Review Panel, will ensure that action in respect of these recommendations is completed. Agencies have already implemented changes as a result of their individual management reviews and the Safeguarding Board will monitor and review action plans to address any outstanding actions.

Children & Young People's Services' Social Care

1 Staff should be reminded that Initial and Core Assessments must be completed in respect of all children in a household within specified timescales. All children must be seen and spoken to individually away from their parents/carers where that is age appropriate and their views recorded. The written assessments should be signed by both practitioners and team managers, the date they are shared with families should be recorded and copies must be kept on file (electronic or paper)

2 The content and structure of Core Assessments should be detailed in a written plan and shared with families and professionals

3 The format for recording visits to children on the CPR should be reviewed to ensure there are headings for all relevant issues to be addressed, that children's views are noted and that they are seen alone where age appropriate

4 Team managers should ensure that written CIN and child protection plans are formulated, reviewed and amended to reflect concerns and changing circumstances. They should also ensure that minutes of CIN and core group meetings are completed and distributed prior to subsequent meetings

5 The current needs and safety requirements of AX and BX should be reviewed by a service manager as in February 2007 their development and emotional well-being remained significantly impaired

C&YPS School and Inclusion Services

6 The policy relating to repeated prosecutions of parents for failing to ensure their children's school attendance should be reviewed. Particular attention should be paid to cases where safeguarding issues are central to the presenting concerns

7 The role and expectations of Truancy Officers in relation to safeguarding and protecting children should be clarified and included in relevant procedures

South Yorkshire Police

8. The existing policy in relation to silent/abandoned 999/112 telephone calls where children and young people are identified as the callers should be reviewed. If the policy is found to be fit for purpose it should be recirculated to ensure call handlers are aware of, and adhere to, its contents

9 Where perpetrators of domestic abuse are under 16, CPR checks must be undertaken and Social Care notified in writing of the incident

Health Services

PCT

10. Audits of school nursing records should be undertaken to evaluate the quality of assessments and recording in order to define expected standards. Particular attention should be paid to the quality of the work in assessing the health needs of children on the CPR and the role of the school nurse should be defined

11. Managers within the area of safeguarding should ensure that staff for whom they are responsible receive regular supervision in relation to child protection/safeguarding

12. The quality of information provided, and the systems used, by the Liaison Health Visitor in identifying A&E attendances requiring follow up should be reviewed and improved as necessary

13. The clinical lead in Health Visiting should ensure, in the absence of health visitors, that families being offered enhanced support should be monitored and reviewed with a view to allocation being prioritised

14. Managers should ensure that all health visitors attend child protection procedural updates at a minimum of two yearly intervals

DASH

15. The admission paperwork currently completed within Adult Mental Health Services should be reviewed to ensure questions are asked in relation to patients' personal circumstances, child care responsibilities and contact with children

16. The training needs of staff working within Know the Score should be reviewed to ensure they understand, and are able to fulfil, their roles and responsibilities in relation to child protection registration and plans, core group activity and core assessments

General Practitioners

17. When adult patients have identified mental health issues which may impact upon their parenting capacity or mean they could pose a risk to children, questions should be asked in relation to their home circumstances, child care responsibilities and contact with children to enable GP's to refer on for protective action

18. The training provided to GP's should be reviewed to ensure it addresses mental health issues and their impact upon child care and protection

Rotherham Safeguarding Children Board

19 The CPR custodian must notify Social Care when a second register check is undertaken within a two year period to ensure that an Initial Assessment is undertaken. A system should be established to ensure that appropriate action is taken

20 The RSC Unit manager should ensure that case conference chairs are able to identify inadequate assessments, unacceptable levels of risk, are sufficiently confident in challenging conference participants and that conference recommendations link directly to required changes and outcomes

21 Training in relation to providing individual management reviews must be provided to Surestart, Connexions and the Youth Offending Service

All Agencies

21 Data recorded on ICT/client information systems must be accurate, relevant, current, appropriately cross-referenced and, alongside file structures, fit for purpose.

22 Where agencies are concerned about the safety of children on the CPR or about the practice of another agency they should put those concerns in writing to senior managers with a copy to the RSCB manager using the guidance in the Safe and Well Protocol

23 Audits should be undertaken to evaluate the quality of practice and decision making in order to ensure appropriate standards are maintained. This should include quality assurance of all relevant documentation, case recording and assessments to ensure consistent application of thresholds and accurate analysis of presenting evidence. Consideration should be given to introducing a system of peer audits as part of this process

24 The quality and effectiveness of single agency child protection training should be evaluated to ensure it is fit for purpose and that it addresses the importance of accurate recording and information sharing

25 All professionals should receive appropriate supervision and both single and multi-agency training in safeguarding/child protection and promoting the welfare of children. Their attendance at training should be mandatory and systems should be established to monitor attendance and to ensure individual records are current. Staff understanding of relevant training and policies and procedures should be monitored via supervision and appraisal processes and any deficits in knowledge and practice identified and addressed

26 Findings from this review should be disseminated to all managers and practitioners across all agencies and should be used to assist revision of training programmes.

Final Version of Executive Summary of a Serious Case Review Overview Report undertaken by Judith Dodd, Independent Consultant.

This document has been produced by Steve Pearson, Communications Manager, and Jim Stewart, Safeguarding Manager, as the independent author subsequently became the independent Chair of Rotherham Safeguarding Children Board.

Approved by Rotherham Safeguarding Children Board in December 2007