Executive Summary

Serious Case Review Overview Report:
Child W

1.Introduction

This document provides the executive summary of an Overview Report which was commissioned by Buckinghamshire's Local Safeguarding Children Board (BSCB) under the requirements of 'Working Together to Safeguard Children' 2006. It followed serious injury to child W when she was 8 months old.

The report is based upon information provided, via the Strategic Serious Cases Review Group (SSCRG), from individual management reviews (IMRs) carried out by agencies that provided services to child W and her family. Individual Management Reviews were provided by:

- Children's Social Care, Buckinghamshire County Council
- Buckinghamshire Primary Care Trust
- Buckinghamshire Hospital Trust.
- Oxfordshire and Buckinghamshire Mental Health Trust.
- Thames Valley Police.

In addition reports to the Panel were provided by;

- Probation
- Education services Buckinghamshire County Council
- Paradigm Housing Association

Background information was provided by the Education Psychology Service of Buckinghamshire County Council

The conclusions and recommendations arising from this review are based on an analysis of the information provided, with the benefit of hindsight and produced in an Independent Overview Report compiled by Laura Eades, Director of Eades Kerswell Strategic Ltd. They are intended to ensure that the lessons learned from this review are incorporated into best practice of the agencies concerned so that practice improvements are sustained and the same lessons do not need to be learned again.

This report examines the actions of the agencies that were involved with child W and her family. It analyses individual agency policies, procedures and decision making and considers how effectively agencies interacted with each other to safeguard child W and to promote her welfare.

2.The Terms of Reference

The Terms of reference were agreed by the SSCRG on 12.08.08 and were updated to reflect new information on 30.09.08 and 05.06.09

The specific terms of reference for this review are:

- The background of the parents of W and whether their behaviour, capacity as parents and lifestyle impacted on the serious risk of harm to W. The Review should consider the involvement of mothers' family and in particular her sister.
- Whether agency processes and procedures were fully followed and whether actions were taken to assess, manage and monitor to the risk of violence from W's father to W and her mother were appropriate and led to good outcomes.
- Analysis of the decision making processes in each agency and how that was shared and what level of information sharing occurred across all agencies.
- The issue of the bail conditions attached to W's father relating to the firearms offence on the 28th April 2008 and the impact of the events in this case need to be fully explored.
- Any pre-birth assessment of the parent's relationship and the likelihood of harm relating to domestic abuse.
- The post-birth referral for services to the Children with Disability team and the quality of assessment of the parental relationship.
- If predictive risk factors were known, were they acted on appropriately? How those risk factors and actions were/were not shared across all agencies.
- Whether practitioners explored the cultural context of this family and any impact on working with professionals.

The general issues to be covered by the review are:

- While addressing the above issues, individual management review report writers must address the questions posed for management reviews on pages 175 and 176 in Working Together to Safeguard Children 2006. In addition the review must contain a root cause analysis in its findings.
- The review should seek to understand the root causes of any failures to act to prevent harm to W by agencies and individuals by ensuring that clear explanations are given for such failures and that where these are not evident, hypotheses are developed and explored.
- In the light of the review consider with hindsight what if anything could have been done differently and what impact such action may or may not have had on the outcome
- The review should identify whether any changes made in policy or practice since the incident leading to this review are likely to have had any impact in protecting W from harm.
- The review should explore and define the key features of good practice illustrated by this case
- There is need to ensure that the recommendations arising from this review reflect adequately the issues raised by the case and that they are ones which will enable changes to be made which will ensure that practice is improved and that measures are taken to ensure that preventable failures are not repeated
- The review should identify any issues of policy either local regional or national that have or may have contributed to failures in the safeguarding system and which should be amended or added to in the light of this review

- The review should consider any racial and or cultural issues that may come to light and consider any disability, physical and mental health factors that could have impacted on the outcomes for child W.

3.Summary of the case

1. Child W is the subject of this review and at the time of the incidents leading to this review was in the first year of her life and had a disability present from birth that caused concerns about her development. Throughout her life, W has had many hospital and medical appointments both for treatment and for therapy relating to her disability.
2. She lived with her mother as an only child and had contact with her father throughout her child hood although he did not live in the same house.
3. During mother's pregnancy, she complained that W's father was violent towards her and that was the reason she did not want to live with him but wanted him to be involved with his child.
4. There was a significant incident in April 2008 when mother reported to Police that W's father had threatened her with an air rifle in her home and she fled taking W with her returning when the father had left and the Police had charged him with an offence.
5. In June 2008, W was thrown from the window of the second floor flat where she lived and her mother and sister were assaulted by her father.
6. W made a good recovery from her injuries which were life threatening and is now thriving and developing well. Although the review was not able to capture her wishes and feelings due to her age, the picture emerges of an engaging child with a huge amount of resilience. The relationship between her and her mother was seen as positive and a good bond had been established.
7. Her father was charged with an offence of attempted murder of W. The criminal proceedings have only recently been concluded (October 2009) with the father pleading guilty and being convicted of GBH with intent in respect of W, ABH of W's mother and Common Assault of her mother's sister.
8. W remains in the care of her mother.
9. The Buckinghamshire LSCB Strategic and Serious Cases Review Group agreed to recommend to the Independent Chair of the LSCB that this case met the criteria laid out in Working Together to Safeguard Children 2006 (DfES) for a SCR and that one should be carried out. The LSCB chair agreed with the recommendation and the review was started in June 2008.

4.The process of the Review

10. The review was carried out according to the Buckinghamshire LSCB safeguarding procedures. The need to conduct a review was agreed in June 2008. The main concern with the review process was the delay in submission of the review to Ofsted caused by the pending criminal proceedings and the advice from the Crown Prosecution Service (CPS) directly to the Serious Case Review Panel meeting and via the panels legal advisor in November 2008, that the father and the key witnesses, W's mother and aunt should not be interviewed for the purposes of the review. The concern was that during the course of the review, there was continuing uncertainty as to who caused the injury to W, who actually threw her out of the window. The risk to the review was that if any party disclosed information pertaining to the proceedings, the review would become part of the criminal case. Subsequently a court order preventing disclosure was issued.

11. The Police were also advised again by CPS not to disclose their IMR to the review panel and there was considerable negotiation between Bucks County Council and the Police about this. This caused further delay to the review and to the completion of the overview report.
12. These two factors led to some discontinuity for the IMR authors in terms of the process of quality assuring them and also cross referencing them for accuracy and for the overview report author. By the time the Police were prepared to disclose their report, the timescale allotted by the overview report author for this piece of work had passed and had to be renegotiated.
13. In this case earlier clarity about the police position would have allowed the review to be completed within agreed timescales but publication and submission would have still had to wait.
14. Not knowing for sure who has perpetrated the crime against W has had minor impact on the review as the understanding of all the agencies was that it was very unlikely to have been W's mother. The profile of her as a victim of domestic abuse and a mother who did here very best to respond to the needs of her baby, developed more strongly during the course of the review.
15. The overview report author had planned to interview both mother and father of W so that they could contribute to the review in line with good practice and learning lessons effectively. This was not possible due to the criminal proceedings and has therefore limited the content of the report. It means that there are gaps in the review regarding how the parents perceived and responded to W's disability and whether or not this had any significant impact on events or the support that mother in particular may have benefited from. W's mother may also have wished to contribute how professionals may have helped her to disclose and deal with the domestic abuse she suffered. Both parents would also have been able to give us a clearer picture of the little girl at the centre of this review. This is speculation, but shows that there are areas that could have been usefully explored in order to learn more. Weighing up the need to complete the review within a reasonable time frame in order for lessons to be learned and changes to be made, versus the value of the potential contribution from the family, the decision to complete the review without the contribution, was appropriate in the circumstances and even more so because of the delay in the criminal proceedings. Guidance was also sought on this matter from the Government Office for the South East who concurred with the advice given and noted that a court order was in place.
16. The Court was asked to contribute any relevant information to this review by the Panels legal advisor but following three further requests, failed to respond.
17. The trial of W's father was scheduled for Spring 2009 but was delayed until Autumn. He pleaded guilty and was convicted of GBH with intent to W, ABH of W's mother and Common Assault of W's aunt. A considerable custodial sentence is likely when sentencing occurs.
18. The SCR Panel for this case agreed that contact should now be made with the parents to advise them of the findings of the review and to seek any contribution from them that would help the LSCB and its member's agencies to improve safeguarding practice. Any relevant actions will be added to the Action Plan for the review, which will be overseen and monitored by the BLSCB.
19. The Action Plan has been collated to include all the recommendations of the review from both the IMRs and the Overview Report. Each agency will identify a named lead person who will be responsible for reporting on all relevant actions to the Monitoring and Evaluation sub-group of the BLSCB and any significant lack of progress plus reporting on impact will be to the main board of the BLSCB.
20. Despite the delay in the process, there was considerable commitment to challenging the decisions that resulted in the case being held up and a desire and commitment by the agencies involved to draw out the learning points and take action to remedy and weaknesses as they were identified. This is particularly so

in relation to the Police, whose submitted actions were virtually all in place by the last SCR Panel meeting.

21. The Serious Case Review Panel was originally chaired by the Divisional Manager, Prevention, Assessment and Protection, but the chair was passed to the Independent Chair of the LSCB midway through the review to reflect the new government guidance, introduced at that stage, to provide greater independence to the process.

Decision to hold a SCR

22. The decision to hold a Serious Case Review in the case of child W is, in the author's view, an appropriate one in meeting the criteria in Working Together to Safeguard Children. The injury to W was a serious and life threatening one caused by a parent in a situation where there is a history of domestic abuse.

5.Lessons to be learned from the process

23. Although the guidance in 'Working Together' that the police conduct of a serious criminal investigation should not affect the timescales for the Serious Case Review, it is the overview author's opinion that this case is an example of where it inevitably does. In this case a court order prevented the disclosure of information to the SSCRG by the Police. The reality is that the ability to inform parents that the review is being undertaken, its purpose, and the opportunity to engage them in the process, all in a sensitive and professional manner is severely impacted upon when a parent is a suspect in a continuing police investigation. Thames Valley Police were, as partners in the process of this review, as cooperative and facilitative as they could be to the SSCRG as it developed the key themes and lessons learned.
24. The process developed by the SSCRG was flexible and open to learning. The overview author was able to contribute to the terms of reference in response to new guidance regarding SCRs and following meetings with the IMR authors which provided new areas for exploration. IMR authors found the process helpful and supportive illustrated by the fact that the final version of the PCT IMR was a much more considered offering than the initial drafts.
25. During the course of the review it became clear that some agencies needed to provide reports detailing their involvement rather than an IMR concerning direct contact with the child and this helped agencies to understand their role and to develop meaningful recommendations.
26. The review identified issues to do with the inconsistent recording of basic information across agencies and in particular the use of names. This was made harder for the Panel as the mother, maternal grandmother and child W had very similar first and middle names.

6.Key learning Points from the review

27. There is nothing in this review in terms of the context for the agencies concerned that would impact on the management of the case. No IMR author has raised issues of staffing problems workload or reorganisation.
28. The root cause of the failure to address the needs of a child with a disability in a holistic way, which may have identified some of the risks to W seems to be the way in which social care services were structured and managed. The Children with Disabilities Team involved in this case were allowed and perhaps

encouraged to see their role as family support workers to the exclusion of holistic assessment and identification of risks and protective factors. It is concerning to note that staff even in hindsight do not think that a section 47 enquiry would have been helpful in protecting W. Performance management in respect of the quality of the initial assessments and the outcomes of the teams work should be highlighting this as a problem for managers to attend to.

29. The root cause of the failure to assess risk to W lies in the lack of organisational understanding of the role of health and social care staff to build good relationships with service users within a framework of sceptical enquiry. Analysis of SCRs nationally (Learning Lessons Taking Action; Ofsted's evaluation of serious case reviews 1st April 2007 to 31st March 2008) demonstrate time and again the rule of optimism that can lead to wrong decisions, and the start again principle which leads workers to ignore history, even very recent history in making judgements about risk. This is not a procedural issue. The processes for asking difficult and probing questions(e.g. about domestic abuse and about the fathers role) at booking appointments home visits and in response to information shared by service users outside more formal interviews are agreed across agencies in Buckinghamshire. However, the confidence of staff to apply an agreed process and to see that as an essential part of their role, supported and monitored by managers seems largely absent in this case.
30. In addition, the root cause of the failure by Police to identify risk to W following the air rifle incident and to reduce the risk to mother from father to medium, lies in the lack of an integrated risk assessment model making sense of what high risk for adult perpetrators and victims means for children where domestic abuse is an issue. The author is aware from her experience of other LSCBs in the Thames Valley Police Area that practice in this regard has improved considerably.
31. A Social Care Institute of Excellence (SCIE) Research Briefing on Children and young people's experiences of domestic violence involving adults in a parenting role says

    "*In their professional assessments, practitioners should be aware that domestic violence may feature in the lives of children and young people in their care. They need to develop systematic screening using an appropriate and sensitive protocol of questions that will draw out domestic violence as a possible cause of physical, emotional or behavioural problems." SCIE Briefing 25 A Worrall Jane Boylan and Diane Roberts June 2008*
32. Supervision is key to this as is a culture where people are bold but not reckless in doing all they can to address the needs of children within their families. Sometimes the need to respect the privacy and confidentiality of the parents leads to an inadequate focus on the needs of the child. The desire of professionals to form a trusting and supportive relationship with the adults they work with is an essential attribute for good children and families workers but it must be coupled with the scepticism necessary to build a relationship based on honest communication and challenge about good enough care of children.
33. The root cause of the injury to W lies in the behaviour of her parents and we do not know enough about the origins of that behaviour to go any further with this in this review. However the services that could have worked more effectively with domestic abuse here were hampered by the lack of background information, a system and process for sharing that information and a clear model for a response to domestic abuse before it has reached a certain threshold. Which agency leads on such a response is still unclear. Police pass on notifications to health visitors and social workers but the assessment they make of risk to the victim from the perpetrator does not apply to any children unless officers have had direct observation of this.

7. Conclusion

34. The above analysis leads to the conclusion that the injuries and trauma experienced by W probably were preventable. The lack of a contribution from the child's parents make it impossible to be more definite.

35. The review certainly highlights the need for all professionals working with vulnerable children to operate within a culture of sceptical enquiry where there is suitable and reasonable challenge to decision making. The current process culture for social care has been taken to task by Lord Lamings latest report.

36. The need for a cultural shift in the way in which organisations work together to assess risk and need in a holistic sense is evident from this review and it is hoped that this will be driven within Buckinghamshire using the lessons learned from local experience.

37. These lessons must be applied to any decision relating to the future outcomes for W and for any subsequent children born to or cared for by her mother and/or father.

8. Recommendations

Overview Report Recommendations

Buckinghamshire LSCB

1. Buckinghamshire LSCB should review the use of the screening tool 'Ask about domestic abuse' and any other such tools that are used by agencies in order to identify whether they are useful and effective tools, whether other tools needs to be developed and whether the policies of the agencies using the tool are supportive of its effective implementation
2. Buckinghamshire LSCB should ensure that all level 1 safeguarding training includes the requirement and expectation that practitioners will formally challenge each other both within and between agencies if they believe that the agency is not responding appropriately to safeguarding concerns.
3. Buckinghamshire LSCB should consider the current framework for the assessment of cases where there are concerns about domestic abuse to ensure that it is well understood, consistently used and that outcomes for children are good. They must make any changes necessary to improve the current system.
4. Buckinghamshire LSCB should provide guidance to front line practitioners on the assessment of vulnerability in first time parents or those who are having a child with a new partner
5. Buckinghamshire LSCB should issue a statement to all agencies about the requirement for extreme care to be taken in the recording of given names and names used by families in all services user/patient records. The Serious Case Review Process should include specific guidance on need to establish a consistent approach to the names by which individuals should be referred to in the course of the review.
6. Buckinghamshire LSCB should ensure that guidance is provided to Housing Associations regarding their safeguarding responsibilities and appropriate responses.

Buckinghamshire Children and Young Peoples Services

7. Buckinghamshire Children and Young Peoples services must assure itself as a matter of urgency that the assessments undertaken by the Children with Disability Teams are addressing safeguarding concerns appropriately and that no children are at risk of suffering significant harm.
8. The service must ensure that the workers involved in this case are aware of their responsibilities and of the requirements for multi agency involvement in assessments.
9. The service must ensure that current practice should be reviewed and appropriate action taken to address any weaknesses in individual or team performance. Current practice should be reviewed and appropriate action taken to address any weaknesses in individual or team performance.
10. Requests for information to GPs should be specific and include questions about family background, culture etc.

Buckinghamshire PCT

11. Buckinghamshire PCT together with GP Practices should strengthen the role of GPs in contributing to assessments of children particularly of preschool age (acknowledging their higher levels of risk from significant harm) This role should be extended beyond a generic request to contribute information to a fuller development of their role in relation to Common Assessments and Initial and Core Assessments.
12. PCT to send a reminder to GPs that opportunities exist for discussion with a community safeguarding health professional – which allow for impressions and underlying concerns to be considered, without compromising patient confidentiality

Police and Probation Services

13. Police and Probation services should champion a review of policy regarding the retention of records where a serious offence has been committed by any person, juvenile or adult against a member of their family or partner. (cf Police recommendation)

14. Thames Valley Police should consider the development of a risk assessment tool in cases of domestic abuse that considers the risk to any children separately to that of risk to the adult(s) involved

Paradigm Housing

15. Paradigm Housing should seek advice from social care professionals and the Police as to the circumstances which may warrant urgent action in attending to the security of their housing provision. It may need to review current procedures and issue guidance to staff.

IMR Recommendations

Buckinghamshire Hospital Trust

1. Booking Interview - The booking interview is seen as a screening process an opportunity to ‘risk assess’ and to identify a plan of care for clients.
   The midwife should be able to ‘tease out issues’ that may have the potential for having a significant impact on the child and make appropriate referrals at

the time to ensure packages of care and support are available for individual needs. This may be a CAF or referral to social care or sharing information with other professionals i.e. HV/GP

2. Staff need to consider the role of the father in assessments.

3. Record Keeping and Documentation for parent/child attachment whilst on SCBU (discussed following a previous SCR) – ongoing work
To remind staff of responsibilities for record keeping
Nursing Records Policy 27.2 – updated June 2007

PCT

1. Thames Valley Police domestic incident reports to be shared with General Practitioners when they report threats to life, use of weapon/s, serious injury of an adult victim or injury of a child.

2. Incident forms to be generated when information is received that there is a potential risk to staff safety and there is a change to service provision as a result

3. Further risk assessment to be carried out prior to resuming regular service provision

4. Community Health Buckinghamshire's domestic violence policy to be reviewed and any changes made disseminated in staff training.

5. Community Health Buckinghamshire to provide training to Specialist Community Practitioners to increase knowledge of legal processes such as bail conditions

6. Community Health Buckinghamshire to ensure Equality and Diversity Training includes understanding of Traveller culture

7. Community Health Buckinghamshire to review requirements and provision of supervision to staff working with vulnerable families

Thames Valley Police

1. TVP considers a review of the current risk assessment process, and the production of corporate guidance on this, which includes guidance for supervisors when reviewing changes in risk level for victims.

2. TVP reviews the training delivered to DAU staff in respect of completing risk assessments.

3. TVP promulgates through the Manager's Briefing the differing needs of victims and witnesses with literacy issues.

4. The DI Public Protection for Buckinghamshire BCU should conduct an inspection of the DAU in April 2009 to ensure that CEDAR use is compliant with force policy, and CAIU flags set where appropriate.

5. The Buckinghamshire DAU needs to ensure that all information captured during the risk assessment process is shared with Children's Social Care, in addition to that shared via the crystal report.

6. That the Protecting Vulnerable People Strategy Unit carry out an audit and inspection process in line with force inspection visits with focus on risk assessments, CEDAR recording issues, victim safety plans and offender management.

7. That TVP seek to agree a protocol with the CPS to ensure that all high risk incidents are subject to a case review/planning meeting prior to the final disposal decision.

8. That TVP reviews the storage policy for case papers held in relation to public protection, sexual and violent crime, and domestic abuse – currently held by the REC for 7 years, in line with the guidance on MOPI, regarding review schedules

Buckinghamshire Children and Young Peoples Services

1. There will be an urgent review of the practice of the workers in this case. Relevant managers in Bucks Social Care will ensure that workers are not continuing to work with vulnerable children unless they have a high level of supervision and further child protection training. Practitioner involved will need to demonstrate they understand the issues arising from the review and are able to make changes to their practice. They must have opportunity to read this report.

2. Social Care should carry out an internal audit of all the work across the three teams working with children with disabilities to ensure that there are no other cases where there are child protection issues that have not been addressed. If any are identified, relevant action must be taken to remedy this.

3. Managers should ensure that in all cases where a child with a disability requires a service under Section 17 of the Children Act 1989, the key social worker should complete a Core Assessment within thirty five days of the initial assessment.

4. In all work with children there should be a full assessment of both the child's parents/carers including meeting and interviewing absent parents. In cases where workers have not been able to undertake an assessment of a parent the reasons for this should be fully recorded.

5. When working with children with disability all efforts must be made to engage the father and undertake work with him on what it means to him to have a child with a disability.

6. The Diversity training should be extended to provide a focus on the mores of Traveller families so that workers will be more sensitive to what it means to have been born to this tradition.

7. Consideration should be given to identifying a specialist worker or organization to advise on cultural issues of this group for workers to refer to and to help improve practice standards.

8. Specific chronologies should be drawn up to meet the needs of the case such as a domestic violence chronology, parental separations and reuniting chronology and attendance at medical appointments chronology.

9. Checklists as tools in domestic abuse should be drawn up and used whenever a social worker becomes aware that domestic abuse might be an issue for a family

Oxfordshire and Buckinghamshire Mental Health NHS Trust

1. All contacts, letters and information shared must be recorded in patient records.

2. All entries in records to be signed and dated in line with OBMH documentation policy.

3. When an appointment is not kept a record stating the reason for not attending should be recorded and if no reason is known, this should be recorded.

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