DERBY

LOCAL SAFEGUARDING CHILDREN BOARD

SERIOUS CASE OVERVIEW
Executive Summary

In respect of

CHILD XX

Born XX.XX.04

Derby Local Safeguarding Children Board

Serious Case Review Executive Summary
Child XX born XX.XX.04

1. This Review was commissioned by the Derby Area Child Protection Committee (ACPC) Serious Case Review Sub-Committee on the 28 April 2005. Since the commission was issued Derby ACPC has been superseded by the Derby Local Safeguarding Children Board (LSCB), established under Section 13 of the Children Act 2004.

2. A review was commissioned because a very young child had been seriously injured ***and*** it was believed that agencies involved in providing services to children and young people could improve their ability to safeguard them and promote their welfare in the future by looking carefully at the circumstances in this case.

3. The Serious Case Review was conducted in line with the guidance set out in Working Together to Safeguard Children (1999) which was in place at the time it began. The Serious Case Review Sub-Committee has also ensured that the review complies requirements of the latest edition of Working Together to Safeguard Children (2006). The review has taken a significant amount of time to complete because of the number of professionals concerned and complexities involved in the case.

4. The review concerns child XX who was born in 2004 with a very significant disability. As a result of this there were a large number of professionals involved with the child. XX was presented to accident and emergency at just under six months of age and admitted to hospital. XX was discharged after two weeks and re-admitted for a second time one week later. Medical investigation found that XX had serious non-accidental injuries. A number of these injuries pre-dated the first hospital admission. Following an investigation, public law legal proceedings were initiated in the family court and XX is now in the permanent care of relatives.

5. A range of partner organisations to local safeguarding arrangements have contributed to this review by undertaking an individual agency review. The contributors are Derby Primary Care Trust, the Derby NHS Foundation Hospital Trust, the Police and the Derby Children and Young People's Department (social care services). The parents of XX were invited to contribute to the review process but did not do so.

6. The individual agency reports have been subject to scrutiny and challenge by the Serious Case Review Sub-Committee. It is important to consider the whole picture of what happened in a case where there has been a serious injury to a child. The aim is to come to a view not only about what individual agencies and professionals might do differently in the future to improve safeguarding arrangements but also to consider how agencies can improve the way they work together to improve those arrangements.

7. A report of the Serious Case Review has been produced by Jean M Hespe. Ms Hespe (a qualified nurse and health visitor with a Masters Degree in Child Protection) is independent of all the agencies and professionals involved in the case.

8. The review has drawn a number of important conclusions that relate to the nature of assessment, diagnosis, consultation and multi-agency working to safeguard children. The review found that in order to maximise agencies opportunities to improve outcomes for children, assessments in complex cases must be partnership based, holistic and consider the whole child. The review highlights the complex nature of diagnosis of child abuse and emphasises the importance of diagnostic tools.

9. The review also identifies that in this case professionals were optimistic and acknowledges that it can be difficult for anyone to believe that an assault on such a vulnerable child could have happened. This is particularly so where the suspected perpetrator is a parent and one who is already known to be under a great deal of stress, in this instance following the birth of a disabled child. The review identifies the importance of professionals seeking advice from specialists in safeguarding where there are a range of views about diagnosis.

10. There were approximately 14 different professionals involved with this family following the birth of XX (excluding hospital doctors and nurses). The review highlights that where a child's needs are complex and there are a range of professionals involved, a lead professional should be appointed. The lead professional will take a principle role and help with co-ordination of realistic service provision. The importance of identifying a lead professional reflects the more recently issued national guidance.

11. The case review also considered the process of the investigation of a suspected case of child abuse following the second admission to hospital. This highlighted the value of holding timely multi-agency meetings to decide the detail of an investigation and a communication plan.

12. The recommendations of the review will support the continual improvement of the very complex practice of assessment and diagnosis of child abuse, in particular in cases where children are disabled. Individual organisations contributing to the review have drawn up action plans that will support the continual improvement of their safeguarding arrangements.

13. Following receipt of the overview report the LSCB will translate its recommendations into an action plan. The plan will identify what action will be taken, by whom, by when, and with what intended outcome. The plan will also set out how improvements in practice will be monitored and reviewed.

Rachel Dickinson
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