

SERIOUS CASE REVIEW

Executive Summary

In respect of:

CHILD A

CHILD B

CHILD C

**Paul Sharkey (MPA)
Independent Overview Writer
March 2010**

Introduction

- 1.1. A Local Safeguarding Children Board is required, in compliance with Chapter 8 of statutory guidance ('Working Together', 2009), to carry out a Serious Case Review (SCR) when a child has died or been seriously harmed and there is cause for concern as to the way the local authority, their Board partners or other relevant persons have worked together to safeguard children.
- 1.2. SCRs are not enquiries into how a child died or was seriously harmed or into who is culpable. That is a matter for coroners and criminal courts, respectively, to determine as appropriate.

Terms of Reference

- 2.1. In accordance with paragraph 8.6 of 'Working Together' (2009) the purpose of this SCR is threefold:
 - To establish what lessons are to be learnt from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children.
 - Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted upon, and what is expected to change as a result; and
 - Improve intra an inter-agency working and better safeguard and promote the welfare of children.
- 2.2. The City of York Safeguarding Children Board (CYSCB) also identified the following additional issues to be included.
 - i. Comment on whether the Individual Management Reviews (IMR) have addressed the terms of reference and relevant issues.
 - ii. Examine the inter-agency working and communications between all involved agencies.
 - iii. Determine whether services which were provided, actions taken and decisions made were in accordance with current policies, procedures and Government guidance at the time.
 - iv. Consider, using the benefit of hindsight, whether different decisions or actions may have led to a different course of events.

- v. Were there indicators of neglect that should reasonably have been acted upon by professionals working with the family?
 - vi. Was the children's dental ill-health considered as a safeguarding issue and responded to effectively?
- 2.3. An Overview Panel of senior multi-agency representatives was convened by the CYSCB to progress the Serious Case Review. The Overview Panel was independently chaired by Mrs Anne McMorris. Mr Paul Sharkey was the independent SCR overview report writer.
- 2.4. Neither Mrs McMorris nor Mr Sharkey had any previous involvement with the City of York Safeguarding Children Board. A dental expert was available to provide expert opinion and advice but, in the event, was not required.
- 2.5. This Review focused primarily on the period from the 25.04.03, when a referral was made to the City of York's Children's Social Care service to the 13.08.09, the date of the decision by City of York Safeguarding Children Board to hold this SCR.
- 2.6. The three subject children and the parents were notified in early January 2010 of the decision to undertake a SCR.
- 2.7. The three children and the parents contributed to the SCR through interviews with the independent overview report writer. The children and parents will have copies of the Executive Summary when it becomes available.
- 2.8. There were no parallel investigations ongoing.
- 2.9. The Overview Panel met on four occasions, these being the 23 October 2009, 27 November 2009, 13 January 2010 and the 2 February 2010. An extension was agreed with Government Office for the SCR to be completed by the 5 March 2010.

Contributors to the Overview Panel

- 3.1. The following agencies provided Individual Management Reviews (IMR) for consideration by the SCR Overview Panel.
- City of York Council Children's Social Care
 - City of York Council, Learning, Culture and Children's Services (School Improvement and Staff Development)

- City of York Council Housing Services Department
- NHS North Yorkshire and York, Community and Mental Health Services
- York Hospitals NHS Foundation Trust
- North Yorkshire Police.
- A background report from Barnsley Children's Care Services on their historic involvement with the family

Members of the Overview Panel

Ann McMorris, Independent Chair of Serious Case Review Panel, North Yorkshire Safeguarding Children Board Manager

Paul Sharkey, Independent Overview Writer

City of York Safeguarding Children Board Manager

0-10 Group Manager, City of York (Children's Social Care)

Detective Chief Inspector, North Yorkshire Police

Designated Nurse, Child Protection, NHS North Yorkshire & York
Principal Solicitor, City of York Council

Children's Services Manager, NSPCC

Assistant Director School Improvement, City of York Council

Head of Housing Services, City of York Council

Key Issues

- 4.1. The three children came from a family where there were previously documented historical concerns about abuse and deficient parenting in regard to their older siblings. These concerns predated the families' arrival as residents in the city of York.
- 4.2. The three children subject to this Review suffered gross dental and serious general neglect whilst in the care of their parents. The children were removed from their parents in early 2009 and placed with foster carers following a Section 47 child protection enquiry. Gross general and dental neglect became very

apparent during the course of the enquiry and all three children became subject to child protection plans under the Neglect category. They ceased to be on child protection plans at a Child Protection Review held later in 2009. The children remain with foster carers, being looked after by the Local Authority under section 20 of the Children Act 1989. They have supervised contact with their parents and are reported to be doing well in their placements.

- 4.3. There were a number of agencies/ services which had involvement with the children and the parents during the period between April 2003 and August 2009. These were the three Schools, the Accident and Emergency Department of the York Hospitals NHS Foundation Trust, the GP, the Dental Service, the School Nursing Service and Children's Social Care.
- 4.4. Early indications of neglect started to emerge in 2007, most obviously with A and B's poor dental state. Gross dental neglect/ hygiene issues with A became very evident at the end of 2007/ beginning of 2008 and would have been known by School 2, the School Nursing Service and A/E. Child A had also attended A/E on five occasions by February 2008 and her behaviour was deteriorating at School at the time of the referral from School 2 to CSC in early February 2008.
- 4.5. Children's Social Care did not undertake a thorough initial assessment in response to this referral. There was no evidence to indicate an exploration of A's wishes to come into care. They did not consult widely enough with the School and the School Nursing service, did not conduct a section 47 enquiry and core assessment and overly focused on the parent's perception of child A's behaviour as being the problem. Child B's situation, in addition to Child C, was not adequately considered in relation to their own safety and wellbeing. There was also poor communication and information sharing between A/E, the School Nursing Service and School 2. Awareness of safeguarding issues and understanding of appropriate thresholds of intervention were also identified as problematic.
- 4.6. An important opportunity was therefore missed in February/ March 2008 for agencies to effectively intervene to safeguard and promote the wellbeing of the three children. If this had been done the children's dental neglect would have been treated earlier. This, in turn may possibly have led to a child protection plan and a possibility of placing the children in foster care, thus perhaps shortening the time of their significant harm. In this sense the services provided, actions taken and decisions made did not accord with current policies, procedures and Government guidance at the time. Thus, with hindsight there could have been a different outcome for the children had there been effective intervention in

February/March 2008 as stated above.

- 4.7. School 3 acted correctly and showed good practice in actively arranging for A to receive much needed dental treatment in August 2008. By this stage A's general neglect would have been very obvious - especially to School 3- and it would have been reasonable to expect that a referral be made to CSC. However, this did not happen when A started her intensive course of dental treatment in mid August 2008 even though it was obvious that she had suffered chronic dental neglect for some time. The connection between dental neglect, significant harm and severe general neglect had not been made by either the Dental Service or the School. Again, given all the circumstances it would seem reasonable to suppose that a child protection referral should have been made to CSC.
- 4.8. Clearly then, in A's case her dental ill health by August 2008 was not considered a safeguarding issue and was thus not responded to effectively by either the Dental Service or School 3, albeit her clinical dental needs were well met.
- 4.9. However, by February 2009, Child B and C's dental neglect had become recognised as a safeguarding issue by the Dental Service and a referral was made to CSC. It was not clear how effectively this was responded to by CSC as this referral episode was superseded by a further referral in early March 2009 when the children were removed from home and placed with foster carers as a consequence of the joint Children's Social Care/Police child protection enquiry.
- 4.10. There are several key lessons that have emerged from this Serious Case Review, some of which have already been captured in the IMRs. These lessons are:
 - The need for professional staff to have a shared and thorough awareness of the signs of child neglect, knowledge of assessment over time in a holistic way in line with the Assessment Framework For Children in Need and their Families and an understanding of appropriate means of intervention.
 - The need for a common and agreed multi-agency understanding of child protection interventions across the children's workforce in cases of child neglect.
 - York District Hospital A & E Department, using the current information systems, need to ensure that they consider the possibility of whether children with multiple A & E attendance might be subject to possible/potential child abuse and/or neglect. Where such concerns exist

they must consult with the Trust's Safeguarding and Child Protection Team and YorOK Index.

- The need for all commissioned Dental Services to recognise that dental neglect is a potential safeguarding issue and know what to do if there are concerns about child abuse and neglect.
- The need for recognition by all professional staff and other agencies that dental neglect is a potential safeguarding issue which may indicate significant harm and require appropriate action to safeguard and promote children's welfare and, if necessary and appropriate, should be referred as a child protection matter to Children's Social Care (CSC).
- The need for the School Nursing Service to recognise its central role in regard to making sense of multiple (often minor) health notifications and ensuring that such notifications are considered as possible/potential indicators of child abuse and neglect.
- The need for York Schools to ensure that safeguarding children (awareness and procedures) is consistently embedded into the culture of the school. Consequently, schools should be compliant with statutory and local guidance. Such compliance should be monitored by the LSCB and Local Authority.
- The need for CSC to ensure that the Referral and Assessment Team is consistent in undertaking thorough and comprehensive initial and core assessments. Assessments should always be subject to rigorous management oversight and audit regarding decision making and quality.
- The need for all agencies to understand and act on the imperative of effectively listening to children and young people, especially in regard to accurately interpreting their wishes and feelings.

Recommendations

- 5.1. Notwithstanding any actions and improvements that may have been made by agencies since March 2009 and mindful of the forthcoming thematic review on Neglect being undertaken by the CYSCB, the following recommendations are made.
- 5.2. The Chair of the City of York Safeguarding Children Board (CYSCB) should ensure that the thematic review is undertaken according to the proposals outlined in appendix C (due to start in May 2010). The thematic review must:
 - i. Ensure suitable learning opportunities are made available for professional staff to develop a thorough awareness and understanding of child neglect, its assessment and appropriate interventions. Such learning opportunities should be available within the first six month of the thematic review.
 - ii. Identify and address impediments to the identification and intervention practices in relation to child neglect.
 - iii. Ensure a common understanding across the children's workforce of thresholds for intervention in relation to child neglect.
- 5.3. The Chief Executive of the York Hospitals NHS Trust should within six months ensure that the York District Hospital A & E Department staff, using the current information systems, consider whether children with multiple A & E attendance are subject to possible/potential child abuse and / or neglect. Where such concerns exist they must consult with the Trust's Safeguarding and Child Protection Team.
- 5.4. The Chief Executive of NHS North Yorkshire and York (commissioners of the PCT) should within six months ensure that all commissioned dental services recognise that dental neglect is a potential safeguarding issue and know what do if there are concerns about child abuse and neglect.
- 5.5. The Chair of the CYSCB should within six months ensure, through a programme of multi-agency learning opportunities and the issuing of guidance, that all professional staff recognise that dental neglect is a potential safeguarding issue, which may indicate significant harm and require appropriate action to safeguard

and promote children's welfare.

- 5.6. The Chief Executive of the York Hospitals NHS Trust should within six months ensure the School Nursing Service is able to make sense of multiple (often minor) health notifications and ensure that such notifications are considered for possible/potential child abuse and neglect.
- 5.7. The Director of York Children's Services should within six months ensure that all York Schools have taken action to consistently embed safeguarding children awareness and procedures into the culture of their school. Consequently, schools should be compliant with statutory and local guidance. Such compliance should be monitored by the LSCB and Local Authority.
- 5.8. The Director of York Children's Services should within six months ensure that Children's Social Care's Referral and Assessment Team is consistent in undertaking thorough and comprehensive initial and core assessments that are subject to rigorous management oversight and audit regarding decision making and quality.
- 5.9. The Chair of the CYSCB should immediately bring to the attention of all staff the importance of listening to children and should ensure within six months that this issue is prioritised within the training strategy of the Board.
- 5.10. The Department for Children Schools and Families should consider how it can best promote the message to dental practitioners nationally through the British Dental Association and any other appropriate channels that dental neglect is a safeguarding issue requiring awareness of potential significant harm and appropriate response in order to safeguard children and young people and promote their welfare.
- 5.11. The Department for Children Schools and Families should be aware of the wording in 'Working together to Safeguard Children 2006' (page 52 point 2.55) which states that consent should be sought from a 'competent child or young person' prior to informing health professionals (other than GP's). This acts as a potential hindrance to safeguarding children and needs reviewing as it does not, in its current wording, promote effective communication.

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