



NOTTINGHAMSHIRE SAFEGUARDING CHILDREN BOARD

**SERIOUS CASE REVIEW
RELATING TO BN**

ETHNIC ORIGIN: WHITE BRITISH

EXECUTIVE SUMMARY

MARCH 2010

**Agreed by Nottinghamshire Safeguarding Children Board: March 2010
(updated April 2010)**

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1. Introduction

Summary of circumstances leading to a serious case review

- 1.1 BN was a disabled child who lived at home with her mother, stepfather and half-brother. She was generally seen to be a happy child, however there were reports of some challenging behaviours, including smearing. Also at times concerns were raised about her care and cleanliness. Given her disabilities, a number of agencies had involvement with BN and her family from her birth. At the time of her death, aged 8 years, she had been attending school and was receiving support from a range of services.
- 1.2 The death of BN was initially considered by the Standing Serious Case Review Panel (SSCRP) of Nottinghamshire's Safeguarding Children Board in September 2009. The Panel was concerned about the circumstances surrounding her death. It was understood that BN had been found with a cord around her neck and that she had been locked in her bedroom for a considerable amount of time. It was also understood that the bedroom was in an extremely unhygienic condition. Given the nature of the death and the contextual concerns, the Panel recommended that a serious case review should be undertaken.

The Serious Case Review Process

- 1.3 Regulation 5 of the Local Safeguarding Children Board Regulations 2006 requires Local Safeguarding Children Boards to undertake Serious Case Reviews in accordance with the government guidance contained in Chapter 8 of Working Together to Safeguard Children. An updated version of Chapter 8 was published in December 2009 during the course of this review and the changes to the guidance set out in the updated chapter were taken into account by the Serious Case Review Panel and the NSCB in the way the review was conducted.
- 1.4 The purpose of a Serious Case Review (as set out in Chapter 8 of Working Together to Safeguard Children) is to:
- Establish what lessons are to be learned 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 on, and what is expected to change as a result; and
 - Improve intra- and inter-agency working and better safeguard and promote the welfare of children.
- 1.5 In this case, Chris Few, the Independent Chair of the Nottinghamshire Safeguarding Children Board (NSCB) made a decision to undertake a serious case review on 21 September 2009 following the death of a child where abuse or neglect was suspected to be a factor.
- 1.6 The following agencies had had contact with the family prior to the child's death and all conducted management reviews of their agencies' actions, which contributed to the overview report:
- Nottinghamshire Children and Young People's Services – Children's Social Care and Play Services
 - Nottinghamshire Children and Young People's Services – Schools and Inclusion Services
 - Nottinghamshire Healthcare NHS Trust
 - Nottinghamshire Community Health
 - NHS Nottinghamshire County (GP Service)
 - Sherwood Forest Hospitals NHS Foundation Trust
 - Nottinghamshire Police
- 1.7 A Serious Case Review Panel was established with the following membership:
- Independent Chair
 - NSCB Development Manager/NSCB Manager
 - Head of Safeguarding and Independent Review, Nottinghamshire Children and Young People's Services
 - Service Director/Service Head Social Work Operations, Nottinghamshire Children and Young People's Services
 - Deputy Director of Quality and Governance/Designated Nurse and Consultant Nurse Safeguarding Children, NHS Nottinghamshire County
 - Associate Director of Social Care, Nottinghamshire Healthcare Trust
 - Deputy Nurse Director/Service Director and Head of Nursing for Children, Sherwood Forest Hospitals NHS Foundation Trust
 - Detective Chief Inspector, Nottinghamshire Police

- 1.8 The NSCB appointed Janet Galley as an Independent Chair for the Serious Case Review Panel and Philippa Evans, a childcare lawyer, as the Independent Author of the Overview Report. An Independent Expert was also appointed to provide specialist advice to the Panel in relation to children with disabilities.

Parallel processes

- 1.9 A criminal investigation has been completed in relation to the circumstances of BN's death. It was felt that her death was the result of a tragic accident. However, both the mother and stepfather received a 12 month custodial sentence having admitted child cruelty.

Family involvement in the review

- 1.10 Given the ongoing criminal proceedings, following agreement with the Police, a letter was sent to the mother and stepfather explaining that the serious case review was being undertaken and its purpose. It is the intention to share the outcome of the review process with the mother and stepfather and this will be achieved in liaison with the Probation service.

2. Key Issues

- 2.1 The key issues addressed in this review were the quality of the assessments of the child, the sibling and the adults in the family; the effectiveness of multi agency involvement; whether risk factors and safeguarding issues were appropriately identified and whether practice guidance in relation to safeguarding disabled children, which was relevant to this case, was followed.
- 2.2 Both the local and national practice guidance on Safeguarding Disabled Children emphasise the importance of putting the child at the centre of the assessment process and making time and resources available to allow the child's voice to be heard. Both sets of practice guidance also seek to promote a high level of awareness among professionals of the risks of harm to disabled children, given that the available UK evidence suggests that disabled children are at greater risk of abuse and neglect than non- disabled children.

3. Findings and Lessons Learned

- 3.1 Many agencies involved had tried to deliver a good service to the child and the family and to improve the child's developmental progress with a view to maximising the child's potential. However, there were lessons to be learned in how such services should be delivered in order that safeguarding issues could be identified and how services could be coordinated so that future multi agency intervention could be more effective in keeping disabled children safe.

3.2 The review identified that the following lessons needed to be learned:

- Disabled children have the right to receive a comprehensive child-focussed assessment of their needs, in which their views and expectations are central, with the full participation of all agencies involved so that the needs of the disabled child are not allowed to mask safeguarding and child protection concerns.
- Those working with disabled children should have a shared understanding of the individual child and the level of the child's physical and learning disabilities so that services can be targeted to meet those needs, any behaviours of the child can be properly understood and risks of harm can be identified. This will enable all agencies to fulfil their safeguarding responsibilities towards such children and to help distinguish between disability and child protection issues.
- Services to individual disabled children should be coordinated to ensure that agencies work together and information sharing can take place within a multi agency framework so that the needs of the child can be met and the safeguarding responsibilities of each agency towards the child are fulfilled.
- The views and experiences of children must be central to all work undertaken. Children must be communicated with directly and their experiences, wishes and feelings placed at the heart of all assessments and interventions.
- All agencies and professionals have a responsibility for acting on, and following up, concerns about a child. They must do this regardless of whether any other agency is involved, and must ensure they receive a satisfactory response to their concerns.
- Agencies need to have an open mind as to the possible range of reasons for a particular kind of behaviour in a child with a disability, and not just attribute it to the disability.
- Professionals still do not always recognise the signs and symptoms of abuse and neglect in children and how to act on them. This could be a particular challenge where the prime focus of intervention begins as one of offering support.
- Where there are concerns about neglect, agencies must be clear with parents about what constitutes acceptable standards of care, and must rigorously monitor this, including regular inspections of all rooms in the property in which children are living.

- The role of management and supervision within all agencies has an important part to play in enabling practitioners to ‘stand back’ from their day-to-day involvement with a case and reflect on what they are seeing. This should include challenging any ‘mind set’ about a particular case, and ensuring that the way in which services for a child are planned and reviewed is evidence-based.

4. Actions Already Taken

4.1 CYPS – Children’s Social Care & Play Services

- Immediately following the death of BN protective action was taken in respect of her half-brother who is the shared child of the mother and stepfather. He is currently placed with foster carers and is the subject of an interim care order. He has settled well in his placement and is making good progress.
- There has been a review of the case responsibilities of those staff immediately responsible for the case at the time of BN’s death. Appropriate managerial action has been taken in response to the findings of the reviews, including an assessment of competence and fitness to practice, focused individual training and development and close monitoring and evaluation of practice. In addition, contact has been made with the employer of one member of staff who had left Nottinghamshire County Council at the time of BN’s death but had a significant role in relation to the casework.
- An independent service review has been commissioned which will include a random case file audit, review of capacity and current management arrangements as well as the implementation of policy and practice guidance in the service. There will also be an assessment of training and development needs for managers and staff. Additional management capacity has been deployed into the service to ensure that there is a clear focus on safeguarding in all casework and to ensure performance is appropriately challenged and addressed.
- The informal practice of classifying some cases as “low level” needs has been stopped. All cases where there are child protection issues have been identified and reviewed by managers.
- Since early 2008 a specialist children’s Occupational Therapy OT service has been developed for disabled children and is managed within Children’s Social Care.
- A decision was made by Nottinghamshire County Council in September 2009 to invest further resources into Children’s Social Care to support front-line staff. This includes investment in administrative support, support for the management of electronic records and the

Integrated Children's System and 12 newly established advanced practitioner posts.

4.2 CYPS Schools and Inclusion Service

- The first school BN attended has reviewed and amended its child protection procedures to ensure all concerns are dealt with robustly. This includes ensuring that individual child protection files are created in appropriate circumstances and the headteacher escalating concerns where necessary. All staff at that school have received refresher safeguarding training appropriate to their role.
- A review of file management processes has taken place within the Inclusion Service

4.3 Nottinghamshire Healthcare Trust

- All referrals to specialist (*Tier 3 and upward*) and targeted (*tier two*) CAMHS are now received through a Single Point of Access; allowing for effective triage and allocation. The internal target for specialist CAMHS is eight weeks from receipt of referral at the single point of access, to allocation. This target is currently met and an exception reporting process in place should any referrals exceed. All referrals are monitored on a daily basis to ensure timeliness of prioritisation based upon nature of referral, urgency and risk.
- Safeguarding children training remains mandatory within the directorate with all staff requiring a minimum of level one training; currently the directorate is achieving 92% in this domain. The Trust is engaged with partners in ongoing work to develop a more comprehensive suite of training.
- CAMHS are in the process of reviewing their documentation to ensure there is robust synergy between that and the Common Assessment Framework, in line with the refocusing of the Care Programme Approach.
- A review of the Did Not Attend and Disengagement policy has been enacted following a previous serious case review.

4.4 Nottinghamshire Community Health

- Internal reviews are underway into some of the issues identified relating to the school nursing service involvement for the period between Jan 2007 and May 2009.
- An electronic patient information system is being implemented across all services to address the fragmentation of children's health records within Nottinghamshire Community Health, with a view to improving communication and access to information across the health

community, which will overcome some of the significant issues identified in this review.

- A Safeguarding Training Strategy, outlining minimum training requirements for all health employees, is now being implemented and compliance monitored through the Care Quality Commission Standards for Better Health.
- A family health assessment tool was ratified within Nottinghamshire Community Health in May 2009 for use across school nursing and health visiting services.
- Changes have been made to the referral criteria within the Community Learning Disability Team, and every case is looked at and followed up by a Clinical Assessment Service, which is a group of Child and Adolescent Health Service professionals, so that even children with mild learning disabilities but complex needs can now access the service.

4.5 Sherwood Forest Hospitals Foundation Trust

- The role of the paediatrician has been reviewed and defined by the Trust. The current expectation of the role is described in the Individual Management Review and reflected in the overview report. The recommendations and action plan reflect how this expectation will be achieved.
- The National Institute for Health and Clinical Excellence guidance on faecal smearing has been widely disseminated and is addressed in safeguarding training for all staff.

5. **Recommendations and Action Plan**

5.1 The Individual Management Reviews prepared for this review contained a range of recommendations covering the learning points identified above, as shown in the action plans published with this Executive Summary. The Independent Author endorsed all these recommendations. The overview report also made the following recommendations, which were presented to the NSCB:

- That the NSCB consider how better to raise the profile of safeguarding issues in relation to disabled children, in line with the recommendations of the Safeguarding Disabled Children: Practice Guidance, issued by the government in July 2009.**
- That the Children's Trust develop coordinated arrangements for the assessment, planning and review of children with disabilities.**

- iii. **That the NSCB agree and implement a policy statement and practice guidance as to the use of door locking as a way of managing the behaviour of children at home.**
- iv. **That the NSCB remind all agencies that all referrals/concerns should be followed up until an appropriate course of action is agreed.**
- v. **That the Chair of the NSCB bring the findings of this review to the attention of the Department of Health and the Department for Children, Schools and Families to ask them to:**
 - * **consider whether further national guidance and direction is needed on the coordination and delivery of services to children with a disability, and specifically**
 - * **issue guidance on acceptable ways of managing the behaviour of children with a disability at home.**
- vi. **That the NSCB and the Children’s Trust work together to consider ways in which they can enhance multi agency working and good practice across all agencies in Nottinghamshire. This should address both front-line practice and management oversight.**

5.2 The NSCB has agreed to the above recommendations and has drawn up a multi agency action plan, which outlines the timeframes within which the actions will be taken. This action plan will also be published with this Executive Summary.

5.3 This action plan will be monitored and the impact of the actions taken evaluated by sub-groups of the NSCB, which will provide regular feedback to the NSCB.

6. Ofsted Evaluation

6.1 The serious case review has been evaluated by Ofsted who judged it to be good.

Signed.....
Chris Few, Independent Chair NSCB

Signed.....
Janet Galley, Independent Chair, Serious Case Review Panel

Signed.....
Philippa Evans, Independent Author, Overview Report