Information Sheets

Serious Case Review Posters

Don't Assume You All Have The Same Information About Me

Main Themes

Sharing information about a child or young person may be the most important thing you do today. We know from serious case reviews, inquests and enquiries over the last century that not sharing information effectively is a factor in all child deaths and serious incidents involving a child.

Sometimes we think that because the police, a GP, or a social worker is involved, that they necessarily know what we know about a given child. They may not. Picking up the phone could save a life. It may be that you have much more insight into a child's day to day experience and that you have many details of their lives that might be relevant. For example, who lives in the home with the child, what are their relationships, has the child sustained an injury, do you know something about a sibling?

Effective information sharing involves understanding the roles and remits of other professionals, and realising their expectations of your role and remit. It is always worth clarifying these when you work with professionals across agencies.

Safeguarding is everyone's responsibility. When a child is subject to a child protection plan, it is the multi-agency group, not just the allocated social worker, who is responsible for their welfare.

Safeguarding is an activity that takes place in a variety of settings and at many levels. Successful safeguarding is wholly reliant upon individual professionals assuming personal responsibility to taking action whenever they suspect abuse, and following it up in a way appropriate to the circumstances. This means being proactive, and being proactive and thorough is time-consuming and yields little immediate reward or professional gratitude.

More often than not, the most important safeguarding activity you will engage in will involve exchanging information with professionals in your own setting and in other agencies. All staff ought to feel empowered and supported by their organisations to assume this responsibility.

Reflective Practice

Are all staff in your setting adequately equipped and empowered to share information effectively and appropriately? What can you share with the multi-agency group to ensure that we share information better?

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Information sharing SCRs – a few examples

Recent / Relevant Serious Case Reviews

- Daniel Jones, Wolverhampton (December 2013)
- Daniel Pelka, Coventry (September 2013)
- Baby C, Buckinghamshire (May 2013)
- Olivia, Essex (August 2013)
- Case No.SOT12(1) Stoke On Trent (February 2013)

December 2013 – **Wolverhampton – Daniel Jones**
Death of a 23-month-old boy in May 2012, as a result of ingesting heroin. Post mortem revealed evidence of regular exposure to heroin. Father was convicted of manslaughter and mother was convicted of causing or allowing the death of a child. Maternal history of drug and alcohol misuse and offending; she had one older child who did not live with the family. Paternal history of prolific offending and drug misuse. Both parents were known to addiction services, had separate key workers, were involved in a methadone programme and were known to have used heroin during Daniel's life. Family was well known to children's services.
Issues identified include: lack of focus on the child; professional optimism; insufficient management and supervision; insufficient information sharing; and working with resistance and avoidance.
Makes various inter-agency and single agency recommendations, covering: Wolverhampton Safeguarding Children Board, health services, children's centres, GPs, police and drug and alcohol services.
Drug misuse, parents with a physical disability, professional optimism

September 2013 - **Coventry - Daniel Pelka**
Death of 4 year old boy on 3 March 2012 as the result of an acute subdural haematoma. Daniel's mother and step father were convicted of murder in August 2013 and sentenced to 30 years' imprisonment. For a period of at least six months prior to his death, Daniel had been starved, assaulted, neglected and abused.
History of incidents of serious domestic abuse and violence, chaotic lifestyle with multiple house moves and alcohol misuse by mother and various partners.
Issues identified include: deception of agencies and services by mother; impact of witnessing violence on children; impact of culture, race and language; and Daniel's isolation and 'invisibility'.
Recommendations include: review of information sharing and notification systems in respect of domestic abuse; ensuring a robust system for recording injuries or welfare concerns by school staff; and guaranteeing health professionals consider child abuse as a differential diagnosis, when assessing the welfare of children who present with unclear concerns.
Child abuse, domestic abuse, alcohol misuse

May 2013 - **Buckinghamshire - Baby C**
Death of a baby boy in October 2011, from a head injury thought to have been caused by shaking. Post mortem revealed additional fractures, which occurred approximately two weeks before Baby C's death. Parents were questioned by police at the time of Baby C's death and a criminal investigation and care proceedings in relation to Baby C's siblings were underway at the time review was published.
History of: maternal depression and panic attacks; maternal cardiac condition; family homelessness and house moves; and claims of racial harassment from neighbours.
Issues identified include: Baby C's slow weight gain; withdrawal of family contact with professionals, now known to have been around the time at which Baby C suffered injuries; and mother's tendency to

exaggerate accounts of her circumstances and difficulties faced by the family.
Recommendations include: arrangements for identification and review of vulnerable families in GP surgeries; promotion of better liaison and information sharing between health visitors, GPs and antenatal services; and development of a consistent national approach to the recording of responses to confidential questioning during pregnancy about domestic abuse.
Non-accidental head injuries, shaking

August 2013 - **Essex - Olivia**
Death of a 2-year-old girl in June 2011, as the result of a gunshot wound. Olivia's father shot Olivia and her mother, who also died, before shooting and injuring himself. Father was found guilty of both murders in May 2012 and received a whole life sentence.
Significant history of domestic abuse involving considerable contact with police. Parents were undergoing an acrimonious separation and custody dispute at the time of the incident and mother was awarded a non-molestation order two months prior to the incident.
Issues identified include: lack of focus on the needs of the children; failure of systems and professionals to find a way to assist mother and children in communicating the full extent of abuse that they were suffering; and lack of agency engagement with father.
Makes various interagency and single agency recommendations covering: children's services, police, family courts and Cafcass.
Domestic abuse, information sharing

August 2013 - **Birmingham - Case No.2010-11/3**
Serious sexual assault of a toddler, Subject Child, by an early years student and staff member, the Perpetrator, at a nursery in Birmingham in 2010. Knowledge of the incident came to light following an accusation by a 13-year-old girl of online grooming in January 2011. Examination of the Perpetrator's computer revealed a number of child abuse images, including videos of the assault against Subject Child.
Issues identified include: recruitment and screening procedures; staff supervision; organisational safeguarding practices and policies; management and team culture; inspection and complaints procedures; and early identification on online sex offenders by police.
Recommendations include: effective recruitment processes that explore motivation and value base; balancing physical environments in nursery settings between a respect for privacy and reducing opportunities to abuse; rigorous inspections of early years settings that examine the implementation of safeguarding policies and procedures; and effective communication across the three relevant arms of the Local Authority: Early Years, Local Authority Designated Officer and Children's Social Care.
Nurseries, child sexual abuse, staff supervision, organisational safeguarding procedures