



**SERIOUS CASE REVIEW USING THE
SIGNIFICANT INCIDENT LEARNING PROCESS
OF THE CIRCUMSTANCES CONCERNING
CHILD R**

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1. Summary of findings and lessons learnt

1.1 This serious case review was undertaken in order to learn lessons about the way that agencies work together to safeguard children in Rotherham. The conclusion of this review is that there was a failure to protect Child R from suffering harm while he was in hospital. The reasons for this include:

- enquiries under Section 47 (Children Act 1989)¹ were not initiated in a timely way when concerns were first identified
- opportunities to assess his parents' care of him and to minimise any risk he continued to be exposed to were not taken
- lack of clarity about the process to be followed and the respective roles and responsibilities of social workers and Police Officers when conducting joint enquiries under s47.
- the uncertainty about whether Child R's symptoms (and the reason he was in hospital) were, at least partially, the result of having been non-accidentally injured
- a failure to recognise that undertaking s47 enquiries is as important when there is uncertainty about whether a child has suffered significant harm as it is when the cause of the harm is obvious.

2. Introduction to the Significant Incident Learning Process (SILP)

2.1 SILP is a learning model which engages front line staff and their managers in reviewing cases, focussing on why those involved acted in a certain way at the time. This way of reviewing is encouraged and supported in the new Working Together to Safeguard Children published in March 2013.

2.2 The SILP model of review adheres to the principles of

- proportionality
- learning from good practice
- the active engagement of practitioners
- engaging with families, and
- systems methodology

2.3 It has been generally accepted that over recent years the Serious Case Review process had become over-bureaucratic and driven by Ofsted ratings. The practitioners in the case have often been marginalised and their potentially valuable contribution to the learning has been under-valued and under-utilised.

2.4 SILPs are characterised by a large number of practitioners, managers and Safeguarding Leads coming together for a learning event. All agency reports are shared in advance and the perspectives and opinions of all those involved are discussed and valued. The same group then come together again to study and debate the first draft of the overview report, and to contribute to the learning and conclusions of the review.

¹ A section 47 enquiry is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child who is suspected of, or likely to be, suffering significant harm.

- 2.5 Rotherham Safeguarding Children Board has requested that the SILP model of review be used to consider the circumstances surrounding the multi-agency response following Child R's hospital admission and subsequent injury. This systems review is being undertaken in order to learn lessons about the way that local agencies work together to safeguard children.
- 2.6 Working Together 2013 states that Serious Case Reviews and other case reviews should be conducted in a way which
- recognises the complex circumstances in which professionals work together to safeguard children; seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
 - seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
 - is transparent about the way data is collected and analysed; and
 - makes use of relevant research and case evidence to inform the findings.
- 2.7 This serious case review has been undertaken using the SILP model, which ensures that these principles have been followed and provides a systems review of the case.

3. Introduction to the Case

- 3.1 The child who is the subject of the review is referred to in this report as Child R. His parents are called Mother and Father. Other family members are referred to by their relationship to Child R e.g. maternal grandmother. There are no other children in Child R's immediate family. A genogram, as understood by the review, is attached at appendix 1.
- 3.2 Child R was just under three weeks old when he was admitted to hospital presenting with symptoms that included vomiting, crying as though in pain, and reportedly not having opened his eyes for some hours. After initially being treated for suspected sepsis, concerns were raised that some of his symptoms may have been due to a non-accidental injury. A child protection investigation subsequently commenced but before it was completed, Child R sustained an injury while in hospital and in the care of Father.
- 3.3 Child R's mother is now 20 years old. His parents are both from a white British background. The review had no information about their faith or religious affiliations.

4. Terms of Reference

See attached at appendix 2

5. The Process

- 5.1 A meeting for authors of individual agency reports was held on 1st May 2014 where the SILP process and expectations of the agency reports was discussed. A full day Learning Event took place on 2nd July 2014. All the agencies involved were represented at the Learning Event including both the report author and a number of the staff and managers who had been involved during the period under review. All the agency reports were available and circulated to attendees before the Learning Event.

- 5.2 Prior to a Recall Day held on 25th July, the first draft of the overview report was circulated to those who had attended the Learning Event. The agencies that attended the Learning Event were again represented on 25th July and participants were able to provide feedback on the contents and clarify their role and perspective. All those involved contributed to the conclusions about the learning from this review.
- 5.3 The Overview Report Author and a representative from Rotherham Safeguarding Children Board met with Mother and Maternal Grandfather's ex-partner after the Learning Event but before the Recall Day. An earlier meeting had not been possible due to South Yorkshire Police requesting that there be no contact. However after negotiations with the reviewers they later agreed to the meeting. The family welcomed the opportunity to share their views and where these contribute to learning, they have been integrated in to this report. It was agreed that if other family members wanted the opportunity to contribute to the Review they would contact the Rotherham Safeguarding Children Board who would make the necessary arrangements.
- 5.4 The review has been chaired by Nicki Pettitt and the overview report author is Jane Scannell. Both are independent child protection social work managers and consultants as well as SILP associate reviewers. Both are entirely independent of Rotherham Safeguarding Children Board and its partner agencies.
- 5.5 The Department for Education expects full publication of Serious Case Reviews unless there are serious reasons why this would not be appropriate. This report has been written with the expectation that it will be published but that decision will be taken by the Rotherham Safeguarding Children Board. It will not be published until after the family have been consulted and until any criminal investigation has been completed. Any media strategy will be devised by the Rotherham Safeguarding Children Board prior to publication.

6. Background

- 6.1 As the scope of the review started from 8th April 2013 (when mother was confirmed as pregnant with Child R) there is no previous agency information about him. Agency reports also confirmed that they had had little previous involvement with either of the parents. Only Children's Social Care noted that that in September 2011 they had had a contact from Father's ex-partner who told them that she had called the Police after seeing him "peering through the window" and expressing concerns about his jealous and controlling behaviour and threats to harm himself. Children's Social Care took no further action in respect of this information.

7. Key practice episodes:

- 7.1 Key practice episodes are episodes that are judged to be significant to understanding the way that the case developed and was handled. The term 'key' emphasises that they do not form a complete history of the case but are a selection of the activity that occurred, and include key information to inform the review.

- 7.2 Although the scope of the review started from 8th April 2013 (when mother was confirmed as pregnant with Child R) it was apparent from the agency reports, and from the staff that attended the Learning Event that the pregnancy had been unremarkable to the extent that both the front line representatives from midwifery and health visiting had no specific recollections about their involvement as it had been a routine case. The fact that Father had not been seen at the home visits undertaken by the Community Midwife and Health Visitor (although he was in the house both times) was not viewed as unusual and no concerns were identified. An ambiguity about exactly where Mother and Child R had been living became apparent later, but at the time these health professionals were unaware of this and it had no relevance to the service they provided.

Key Practice Episode 1 – Child R's admission to Hospital 1 Wednesday 18th December

- 7.3 Initially Child R's condition - which caused a senior member of the nursing staff working with him during his first night in hospital to feel "very worried" about him - was being attributed to infection and he was treated accordingly. Various medical investigative processes were undertaken the following day, including a brain scan which identified that he may have suffered a subdural haematoma. Consultant Paediatrician 1 spoke with Mother and ascertained her account of the precedents to Child R's admission which was that Child R had had been sick several times over the preceding two or three days (Mother had reported this to a Nursery Nurse from the Health Visiting Team who had visited on 17th December) but that he was awake and alert in the morning of the day he was admitted. She had left him in the care of Father but when she returned approximately three hours later she had found him to be pale and lethargic and so had taken him to the Walk-in Centre.
- 7.4 During the day there were discussions between the Hospital 1 Consultant Paediatrician and colleagues at Hospital 2 and the potential differential diagnoses of infection, and/or trauma from either a birth related injury or a non-accidental injury, emerged. Medical staff at the Learning Event emphasised the complex inter-relationship between Child R's symptoms and the need to treat the symptoms and, in the process, rule in or out their possible causes.
- 7.5 Further investigative tests were instigated and it was decided that Child R needed the specialist neurological input available at Hospital 2. The Consultant Paediatrician 1 spoke to Mother and informed her of the need to refer to Children's Social Care in light of the possibility that Child R had received a non-accidental injury and in the early hours of Saturday 21st December she spoke to Children's Social Care's Out of Hours Service by telephone. At the Learning Event the fact that a senior doctor had felt it necessary to personally contact Children's Social Care in the middle of the night was commented on as it was felt that it illustrated the significance of the concern felt by an experienced doctor.
- 7.6 The call was made at 00.15 on Saturday 21st December and the Out of Hours social worker on duty at the time contacted their team manager who advised that a strategy discussion should take place later in the morning. The Reviewers felt this was a reasonable decision, although the rationale should have been recorded. A discussion between a member of the Out of Hours team – who is not a qualified social worker – and the Police took place at around mid-day. The review learnt that there are two Out of Hours workers on duty at the same time during the day, at least one of whom would have been a qualified social worker. The

Reviewers were told that it was not unusual for the unqualified member of the team to undertake discussions with the Police on behalf of the team, the rationale being that their qualified colleague was available to provide oversight and advice. The day time Out of Hours team prioritise tasks left to be done by their over-night colleagues as well as those that come in once they come on duty and this accounted for why the discussion regarding Child R did not happen until mid-day. The status of the discussion that took place is ambiguous but it is clear that it did not cover the areas expected in either Working Together 2013 (DfE) (statutory guidance) or in Rotherham Safeguarding Children Board Safeguarding Children Procedures. The lack of clarity of roles and responsibilities and of adhering to process is a theme that pervades much of the key practice episodes and will be considered further later in this report.

- 7.7 The Out of Hours worker spoke with an officer from the Police Response Unit, not from the dedicated child abuse team in the Public Protection Unit. At the Learning Event the Out of Hours worker confirmed that she had tried to speak to a Public Protection Unit officer but one had not been available. The Police representatives explained that a Public Protection Unit officer would have been working but may have been involved in another case and that there is now an improved service being provided due to “force-wide cover” from the Central Referral Unit of the Public Protection Unit and Out of Hours staff are able to contact Public Protection Unit via the Police control room.
- 7.8 The outcome of the discussion as recorded by Children's Social Care was that “*no action could be taken until medical services determine the cause of the injury*” and that “*Child R is deemed safe at this time*”. This implies that some consideration had been given to ongoing risk to Child R although the Children's Social Care agency report author concluded that “there was no rationale for this assessment”. At the Learning Event the Out of Hours worker clarified that prior to the discussion she had got an update from Hospital 1 and understood there was a lack of consensus about the cause of Child R's condition. This informed the decision by both agencies to wait “until a firm cause for concern might arise” (Police Agency Report). The Police Response Unit continued to keep the referral open and as various inspectors came on duty they ensured that the hospital was contacted for an update on Child R's condition. At the Learning Event the Police representatives explained that their colleagues would have wanted to establish whether he “had deteriorated” because if so they would “kick off the criminal process”.
- 7.9 The fact that this early discussion took place with the locality policing unit rather than a specialist officer from the Public Protection Unit was reflected upon at the Learning Event. Children's Social Care staff noted the fact that they have a “good working relationship” with uniformed police officers which meant that the discussion was not compromised. The Police representatives were also clear they felt the fact that the Public Protection Unit were not involved at this time “did not impact on the process undertaken”. However the reviewers feel that the fact that the specialist Public Protection Unit was not involved at this early stage contributed to the lack of clarity about the investigation's status.
- 7.10 On Saturday morning Child R was transferred to Hospital 2. The agency report identified that a “comprehensive transfer letter” including “safeguarding information” was sent by Consultant Paediatrician 1 to clinicians in Hospital 2. His parents continued to have

unrestricted access, with his mother travelling in the ambulance with him.

- 7.11 This is a key practice episode because it was identified that Child R may have suffered a non-accidental injury which needed the agencies responsible for undertaking child protection enquiries to initiate appropriate processes, including whether there were sufficient safeguards in place while he was in hospital.

Key Practice Episode 2 - Child R's stay in Hospital 2 from Saturday 21st December – Friday 27th December

- 7.12 During Child R's first day in Hospital 2, further clinical investigations were completed but the uncertainty about the cause of his condition remained. Medical staff at the Learning Event explained that when a patient's symptoms fit several different diagnoses it is a case of treating the symptoms and trying to rule out the various differentials in the process by analysing the patient's response and continuing with assessments. In Child R's case, for instance, it was remarked that for a baby to have made such a quick recovery from the acute stage suggested that infection was a less likely cause of his symptoms.

- 7.13 The next day (Sunday 22nd December) Consultant Paediatrician 2 made contact with Children's Social Care (still the Out of Hours team) and confirmed that the hospital was still pursuing differential diagnoses and that non-accidental injury was included as a possible cause. The doctor informed the Out of Hours worker of the history obtained from parents which included the information that Child R had been in the sole care of his father between 11.00 am and 2pm on the day he became unwell. The Out of Hours team were made aware that the parents were having unrestricted access to Child R in hospital and were asked if this was felt to be appropriate. The Out of Hours worker undertook to discuss with their manager but there is no record of this having been done and Hospital 2 were not called back by the Out of Hours team as agreed. This was the first time that there is evidence that the issue of parental contact was overtly considered.

- 7.14 On Monday 23rd December ophthalmic tests and a skeletal survey were undertaken but the differential causes of Child R's symptoms remained. The hospital record indicate that Children's Social Care were contacted to inform of a ward move and to ask who the allocated worker was. The Children's Social Care records indicate that their first communication with Hospital 2 happened on the next day.

- 7.15 Apart from the above, the only professional activity relating to the case occurred within Children's Social Care when the Contact and Referral Team referred the case (which they had been notified of by the Out of Hours service) to one of the Duty Teams. The duty team's response was for the manager to email the manager of the Contact and Referral Team service asking them not to "send the case again unless it is deemed a non-accidental injury" (Children's Social Care agency report). There is no evidence of Contact and Referral Team challenging this instruction. At the Learning Event practitioners reflected on the impact that the uncertainty of the medical diagnosis had on their behaviour and actions. Hospital/medical staff clarified that they thought that by this time the threshold for initiating a s47 child protection enquiry had been met, but the Children's Social Care and the Police felt they were "still monitoring" and that because there was a possibility that the cause of Child R's

condition may be meningitis, they needed to act sensitively and gather more information before they could decide on what course of action to take.

7.16 The next day - Christmas Eve – staff at Hospital 2 liaised amongst themselves and with colleagues at Hospital 1 and the issue of parental contact was discussed. The Safeguarding Nurse then spoke with a Contact and Referral Team social worker who recorded that “*by agreeing to unsupervised contact we could be potentially putting (Child R) at risk of suffering significant harm*”. According to the hospital report the social worker suggested that the Staff Nurse spoke to the Consultant in charge. A subsequent telephone conversation between Hospital 2 and Contact and Referral Team resulted in the Children's Social Care Team Manager recording that, because there was still uncertainty about the cause of Child R's condition, “*parents are not to have complete unsupervised contact*”. Neither agencies' recording had any information about what this meant in practice and it is also clear that Children's Social Care were not aware of the actual level of contact that parents were having with Child R while he was in hospital.

7.17 A further telephone conversation was held between a Registrar from Hospital 2 and Out of Hours service in the early evening in an effort to clarify the issue. During this conversation the Registrar emphasised that there was significant concern that non-accidental injury was a possibility. The Out of Hours worker agreed to consult her manager but did not receive a response to the message she left for the manager and the hospital were not given any further information.

7.18 The only other action relevant to the review which was undertaken in this period was the hospital's record that the Paediatric Consultant 3 had a conversation with a Police Sergeant in the Local Policing Team (*not* Public Protection Unit) to explain the difficulties in reaching a definitive conclusion about the cause of Child R's condition. The outcome of this conversation was the setting up of a password-protected system for communicating between agencies in case of the media or non-family members requesting information. However, it was established at the Learning Event that the Consultant appeared to have assumed he was speaking with a Police Officer who would progress the investigation the Hospital presumed was now under way.

7.19 This is a key practice episode because of the lack of clarity about the case's status, the delay in progressing any assessment, and the first consideration of the parent's contact with Child R.

Key Practice Episode 3 - Child R's continued stay in Hospital 2 from 27th December - 14th January 2014 and the initiation of child protection enquiries

7.20 At 4.00pm on Friday 27th December a letter was faxed from Consultant 3 to Children's Social Care. This letter, which was handwritten, contained details of the history given by Father, Child R's treatment and stated that “*while infection remains a possibility and so treatment for this continues, certain features raise very real concerns about possible NAI*”. Receiving this letter precipitated the case being progressed to a referral on the Children's Social Care recording system and the team manager of the Duty Team allocating (on the I.T. system) to a Social Worker with the (written) instructions to commence a s47 investigation and a core

assessment. This was not done face to face as the worker had left for the day and the manager was on leave on Monday 30th December. The Team Manager clarified that the system for allocating work has now changed and that it is now done via an allocations meeting thus enabling discussion, planning etc. to take place face to face.

- 7.21 At the Learning Event it was recognised that Consultant 3's letter was the catalyst for Children's Social Care to progress the case to a referral, meaning the criteria for social care involvement had been met. When asked whether the letter contained information that they were not already aware of, Children's Social Care staff conceded that they had already got the information – the difference was “getting it in writing”, although some felt the letter was more explicit about the high probability that Child R had received a non-accidental injury.
- 7.22 On Monday 30th December the social worker initiated a strategy discussion with a Police Officer from the Public Protection Unit and agreed that the threshold for a joint investigation was met. They decided that a strategy meeting involving the health professionals was needed and, as Consultant 3 who they felt it was essential to be there was on leave until 3rd January, they agreed that the meeting would wait until then. Although participants at the Learning Event agreed that the strategy meeting should have been held much sooner, they agreed this further delay was unavoidable.
- 7.23 Hospital records indicate that the Police Officer had asked the Social Worker not to contact the parents until after the strategy meeting and at the Learning Event the Police representatives confirmed this. When questioned as to the rationale for this, concern about potential contamination of any subsequent criminal investigation was cited. However, as medical colleagues pointed out, they had already told parents that non-accidental injury was considered a possibility and had obtained their “story” of events which potentially compromised any subsequent forensic interview. The Police Officer has subsequently reflected that she had not intended that the social worker should not talk to the family at all, rather that he should avoid direct questioning around the circumstances that led to Child R's admission to hospital and that the strategy discussion should have clarified this.
- 7.24 The strategy discussion also “agreed that visiting arrangements remain unchanged until discussion at the strategy meeting” (Children's Social Care report). Staff at the Learning Event clarified that they had known that that Child R's bed/cubicle was near the nursing station and that “hospital staff were aware of the concerns” and had felt this was sufficient protection until further clarification of risk was available at the strategy meeting.
- 7.25 At this time it is apparent that information that Father had been involved in an incident of domestic abuse against his previous partner in 2011 was known and also that this partner had a three year old child. It was believed that Father was the also the father of this child although it eventually became known to some – although others only became aware of this at the Learning Event - that this was not the case, although he was a significant person in the child's life.
- 7.26 On 3rd January the strategy meeting was held at Hospital 2. It was chaired by Children's Social Care who also minuted the meeting. These minutes do not appear to have been circulated subsequently although individual agency reports identify that participants made their own

notes. The potential differing diagnoses and the continuing high probability of non-accidental injury being at least a partial explanation for Child R's condition were discussed. The meeting also concluded that Child R would be ready for discharge on 9^h January and that a discharge planning meeting would be held on the 8th. It was stated that he could not be discharged to his parent's care and that alternative family members would be assessed as potential alternative carers. There was some discussion about parents' current access to Child R and it was concluded the fact his bed/room was next to the nursing station offered a degree of oversight. It was agreed that parents should not take him off the ward and that Hospital 2 would notify Children's Social Care if he was transferred to another ward.

- 7.27 At this point no investigation, either by the Police or by Children's Social Care, had yet started and the only recorded information about the parents was that their "excellent care" had been noted at the strategy meeting. At the Learning Event Children's Social Care explained that the rationale behind the decision that Child R could not be discharged to his parents' care, once well enough, was that there was now clarity that there was "significant concern" that his condition was due to non-accidental injury.
- 7.28 Following the strategy meeting the Social Worker, their Team Manager and two police officers met with the parents. This was the first time any representatives from the key child protection agencies had had any contact with them. The Social Worker and Team Manager spent some time with mother, who was "very distressed", trying to gain her understanding of why Child R was in hospital and explaining the assessment process. Mother's recollection of this meeting is considered further in the analysis section.
- 7.29 On Monday 6th January Children's Social Care held an internal planning meeting to consider the outcome of the strategy meeting held at the end of the previous week. Although the meeting confirmed that, due to the concerns and inconsistencies in the parents' version of events, he could not be discharged to their care and that any contact Father had with the three year old daughter of his previous partner - who at the time was thought to be his daughter – needed to be assessed. Consideration of whether ongoing contact/access to Child R needed to be supervised was not recorded as being considered.
- 7.30 Two days later, on 8th January, a Discharge Planning meeting was held at Hospital 2 which was informed that Children's Social Care's plan was for Child R to be discharged to the care of his maternal grandmother who would supervise parents' contact. However this plan later changed when information provided by Mother about her and Child R's living arrangements at the time he became ill indicated that Maternal Grandmother may have had sole care of him at some point. Children's Social Care decided that alternative arrangements would need to be made and started the process of identifying other family members who may be appropriate carers.
- 7.31 However, prior to Child R becoming medically fit to be discharged there was an incident on the ward when a support worker heard Child R crying while in the care of Father - "dad was visibly frustrated, the support worker heard a thud and when she approached to see what was happening father was nursing Child R who was still crying, mother arrived at this time and father becomes angry with her, arguing with her about how long she had been gone from the ward". This incident was not shared with other professionals and appears to have

been viewed at the time as a not unusual occurrence in the tense, worrying environment of a children's ward where parents are often stressed. However, with the benefit of hindsight it assumes more significance, and given that this was a child where a s47 enquiry was ongoing, Hospital 2 staff at the Learning Event recognised that it should have been shared, at least with the lead child protection staff within the hospital who could have assessed its significance and taken responsibility for informing Children's Social Care. Hospital 2 subsequently clarified recent increases in staffing within the Safeguarding Nurses team has enabled them to visit the wards daily where there are children with safeguarding concerns and so receive an update from the previous day / weekend. Had this been in place in January it is possible that this information would have been shared and could have contributed to the assessment of the risk the parents posed.

7.32 This is a key practice episode because this is when a decision was made by Children's Social Care that the threshold for s47 enquiries was met. A strategy meeting was held but it was not effective in planning the concurrent police and Children's Social Care investigations that needed to take place and did not consider whether there were any immediate risks to Child R or make appropriate plans to reduce them.

Key Practice Episode 4 Child R's second stay in Hospital 1 14th January - 3rd February 2014 when Child R is injured

7.33 Child R transferred back to Hospital 1 on 14th January. Although he was medically fit to be discharged, Children's Social Care were still in the process of identifying an appropriate family member to care for him and to supervise parental contact. At the Learning Event it was clarified that had a placement been available, Child R could have been discharged in to the community at this time. However, Mother and Maternal Grandfather's ex-partner told the Overview Report author that they had not been aware of this and were under the impression that Child R still needed hospital treatment. Professionals saw transferring Child R to Hospital 1 as way of ensuring his safety whilst allowing time to assess family members. Once again the issue of parents' unsupervised access to Child R was raised by hospital staff and Children's Social Care again confirmed that they felt that the fact Child R's bed/cubicle was close to the nursing station offered sufficient monitoring.

7.34 On 16th January a case discussion was held between Children's Social Care key staff and the LA legal representative which resulted in an agreement to support a voluntary placement with maternal grandfather's ex-partner with the plan to get approval from the Multi-Agency Support Panel to seek a Residence Order in favour of her and a Supervision Order. The fact that an initial child protection conference was not initiated at this time is considered in the analysis section of this report.

7.35 By Friday 17th January hospital staff were made aware that Maternal Grandfather's ex-partner had been approved as an appropriate carer/supervisor and anticipated a discharge planning meeting would confirm this and make the necessary arrangements to transfer Child R's medical care back to community based staff. Children's Social Care felt that the first Discharge Planning Meeting held at Hospital 2 covered the issues sufficiently and that a further meeting was not needed. However one was provisionally arranged for the following Tuesday (21st January) and the parents, who had been under the impression Child R could leave hospital

that day, were told.

- 7.36 Parents continued to have unrestricted contact with one or other of them staying overnight with Child R as they had done throughout his hospitalisation. In the early hours of Tuesday 21st January Father informed nursing staff that he had tripped over the cot wheel while holding Child R and had dropped him face down on to the bed. The nurse noted two bruises on Child R's forehead and informed the doctor on call who saw Child R within 10 minutes. Father gave a slightly different account of how the incident had occurred to the doctor and the doctor noted bruising and that it was *"an unusual pattern for the mechanism...from soft surface"*. The opinion of a more senior doctor was sought who also concluded that he was *"unsure how this accident could lead to injuries like this"*. Although both these two doctors were aware that there was an ongoing child protection investigation in relation to Child R, his father remained with him for the rest of the night.
- 7.37 The injuries and Father's account was further reviewed by a Locum Consultant Paediatrician in the morning. In addition to his previous account, Father described catching Child R by the legs to stop him falling further and on examination bruising was visible on Child R's thigh. Although this explanation was considered *"consistent, reproducible and plausible"* it was also recorded that there was ambiguity over how the two marks on his head could be caused by falling on to a soft surface (a mattress). Further tests were arranged and Children's Social Care were informed of the incident.
- 7.38 Children's Social Care recorded that until this time they were not aware that the parents had had overnight care of Child R and decided that another strategy meeting should be convened to progress a s47 enquiry into this incident. It was also decided that all contact between parents and Child R should be supervised by Maternal Grandfather's ex-partner and that Mother could have contact between 8am and 8pm and Father for an hour a day. Mother and Maternal Grandfather's ex partner's recollection was that initially Mother was told that her contact would only be an hour a week.
- 7.39 A duty social worker attended a strategy meeting at the hospital that afternoon. Although not explicit in any of the Agency reports it appears that this meeting confirmed the Children's Social Care plans and that the police should undertake forensic investigation into the previous night's incident.
- 7.40 Medical tests on Child R concluded that, apart from the bruising, he had not suffered any further injuries as a result of this incident. The contact arrangements agreed at the strategy meeting were incorporated into a Child Protection Agreement which was signed by the Mother, Maternal Grandfather, Maternal Grandfather's ex-partner and social worker. The document is dated 23rd Jan but the signatures are dated 16.1.14 – the reason for this discrepancy remains unclear.
- 7.41 Child R's remaining stay in Hospital 1 was uneventful and after a further Discharge Planning Meeting on 3rd February 2014 he was discharged to the care of his Maternal Grandfather's ex-partner.
- 7.42 This is a key practice episode because although he still needed further tests to be completed,

Child R could have been discharged from hospital. However as assessments of family members as safe carers were not yet completed he had to stay in hospital. Although hospital was viewed as a safe place to be, Child R was injured again.

8. Analysis by theme

8.1 From the information extrapolated from the agency reports, from the discussions at the Learning Event and from the meeting with family members, several key themes emerged. These can be summarised as:

- Conducting a child protection investigation- including strategy discussions and meetings, initial child protection conferences, care proceedings, and links with criminal investigations
- Agencies' response when there is uncertainty about the cause of an injury to a child
- Perception of hospitals as a place of safety
- The balance between a child's need for protection versus the need for attachment – the need for proportionality
- Maintaining momentum, ownership and management oversight over a time period which includes weekends and Bank Holidays
- Information sharing and recording
- Engagement with family

8.2 Viewed from a systemic perspective it is apparent how these themes influenced and impacted on each other and led to the circumstances which are the reason for this review. This is illustrated by how ambiguity in one part of the system - the medical part - caused other parts of the system to behave in a way that compounded the impact of this lack of certainty.

The child protection investigation

8.3 The lack of clarity about process is a theme that pervades much of the key practice episodes. The issues identified pose the questions - why did the strategy discussions and meetings not achieve the outcomes they are designed to and agree the need to progress an assessment into the family's circumstances and the context in which Child R became ill? Why did they not consider the level of risk he continued to face and, as proved necessary, initiate a criminal enquiry from the first referral from the Hospital 1?

8.4 The Children's Social Care agency author report was clear in his analysis that the basic expectations in relation to the child protection procedures were not followed in this case. The strategy discussions and meetings were particularly identified as not meeting the requirements of statutory guidance in that they did not “determine the child’s welfare and plan rapid future action if there is reasonable cause to suspect the child is suffering, or is likely to suffer significant harm” (Working Together 2013). At the Learning Event a number of potential factors were identified that may have impacted on this including the fact that the initial discussion was undertaken by an unqualified worker and a police officer from the Police Response Unit rather than a specialist officer from the Public Protection Unit. The discussion that did agree that a s47 should be initiated was not undertaken by people “sufficiently senior and able to contribute to the discussions and to make decisions on behalf

of their agencies.” (Rotherham LSCB Safeguarding Children Procedures).

- 8.5 Staff confirmed that the Rotherham Safeguarding Children Board Safeguarding Children Procedures are widely available and their use monitored which confirms they are regularly accessed by staff. Therefore it appears unlikely that practitioners are not aware of both the procedures that need to be followed and the associated practice guidance that the Rotherham Safeguarding Children Board procedures also contains. The participants at the Learning Event felt that rationale for the procedures not being followed in this case was the unusual features caused by the differential diagnosis. However, the reviewers did not feel confident that this was entirely the case as there were number of elements that indicated that certain non-procedural activities were part of custom and practice. These include unqualified workers having strategy discussions with the police, not always holding initial child protection conferences when a s47 investigation concludes that concerns are substantiated and the child is judged to be suffering, or likely to suffer, significant harm. This suggests the issues may be more endemic than generally thought. The fact that the Procedures also use outdated terminology, for example in the referring to particular teams' and professionals' responsibilities, means that they are likely to be confusing to staff who are unfamiliar with Rotherham's previous arrangements. In addition, the section on strategy discussion could lead to ambiguity about when in the investigatory process a strategy discussion should be held.
- 8.6 There were a number of factors which compromised the effectiveness of the strategy meeting at the Hospital 2 including the chairing and minuting of the meeting, the length of time available and the fact that much of the information shared was of a complex medical nature which non-medically trained practitioners found daunting and difficult to understand. Instead of focussing on the key requirements of strategy meetings, the meeting was confused by the number of potential explanations for Child R's condition and the limited time did not allow for a thorough shared understanding of the issues.
- 8.7 The Team Manager had to both chair and minute the meeting. This is an onerous burden on someone who needed to have the capacity to concentrate on understanding and questioning the complex nature of the information being shared and having a minute-taker may have enabled her to focus more clearly on the issues that needed to be resolved. Research has shown that where front-line staff and their managers do not have adequate administrative support, their efficiency is impaired and impacts on how they feel about their role. (Forrester et al, 2013).
- 8.8 Had a strategy discussion or meeting involving appropriate representatives from the three key agencies and covering the stipulated issues been held in a timely way when Child R was first admitted to hospital it is possible that different outcomes would have followed. An 'area for improvement' following the Ofsted inspection of Rotherham's safeguarding arrangements in July 2012 identified that to improve the quality of help and protection given to children 'immediate' action was required to ensure all strategy discussions meet statutory requirements, were clearly and fully recorded and signed off by a manager. This suggests that this case illustrates a longer standing systemic issue and is not an isolated incident.
- 8.9 The Reviewers have considered the document provided by Hospital 2 which outlines the

“pre-discharge arrangements for in-patients up to 2 years of age admitted for NAI investigations” and feel that this document potentially adds confusion to the definition and differences between strategy and discharge planning meetings and so recommend that it is not adopted.

- 8.10 Because of the delay caused by the lack of purposeful strategy discussions, the Social Worker did not meet with the family until more than two weeks after the Hospital 1 had referred what they felt were child protection concerns to Children's Social Care. Participants commented positively about the momentum the allocated social worker brought to the case once he became involved and the family also spoke warmly of him as an individual who they had found supportive. However, it was clarified at the Learning Event that he was a newly qualified social worker in his Assessed and Supported Year of Practice (ASYE). Had the allocated worker been more experienced – or had been more closely supported by a manager or senior colleague – it is possible that he might have challenged and clarified the Police Officer's request that he did not speak to the family until after the strategy meeting.
- 8.11 The logic of this request is not clear. The Police Report refers to not doing a criminal investigation but that a joint investigation “will take place between police and social care” implying that they were intending to investigate. At the Learning Event the Police representatives made it clear that they felt that until there was definite evidence from the medical staff that Child R's condition had been caused by a non-accidental injury, they did not believe there was an investigative role for them. However they also stated that the reason they had asked the social worker not to speak to the family was to ensure that any evidence was not contaminated. The contradictory nature of the Police stance was explored at the Learning Event. It was pointed out that the family were aware that the possibility that Child R may have suffered a non-accidental injury was being considered and had provided “the story” of his admission to hospital to the medical staff several times, so the forensic quality of any evidence they provided was possibly already compromised. Undertaking a joint investigation is a complex undertaking and the key professionals need to have a clear understanding of each agencies' roles and responsibilities and be able to have respectful conversations about relative priorities
- 8.12 When a social work assessment undertaken under s47 concludes that the concerns about a child are substantiated and the child is likely to suffer significant harm, Working Together 2013 states that an initial child protection conference should be held within 15 days of the strategy meeting that initiated the investigation. None of the agency reports identified that an initial child protection conference would have been appropriate in this case and similarly, at the Learning Event participants did not appear to have considered this. When prompted by the Review Chair to consider this, Children's Social Care representatives reflected that, in this case, the Multi-Agency Support Panel meeting had superseded the need for a conference. However, the reviewers feel that not having a child protection conference was a lost opportunity to “bring together family members (and the child where appropriate), with the supporters, advocates and professionals most involved with the child and family, to make decisions about the child’s future safety, health and development” (Working Together 2013). It would have been chaired by a professional not previously involved in the case who could have brought an element of independence and fresh thinking to the situation which would have been particularly useful in this case given the uncertainties. It was not possible to

establish whether holding Multi-Agency Support Panels as alternatives to initial child protection conferences is a regular occurrence in Rotherham – anecdotally Children's Social Care and Rotherham Local Safeguarding Board staff felt that it was not, but further consideration of this, as well the threshold for commissioning an initial child protection conference, is warranted.

Agencies' response when there is uncertainty about the cause of an injury to a child

- 8.13 Following the Coventry Local Safeguarding Board's SCR into the death of Daniel Pelka, the Royal College of Paediatrics and Child Health issued a directive that staff should consider child abuse as a differential diagnosis in child health assessments and it is clear that, in Child R's case, medical professionals were alert to the possibility that Child R's condition could be, at least partially, attributable to a non-accidental injury. However the Police representatives at the Learning Event were very explicit that they felt that the threshold for undertaking a criminal investigation was not met as medical opinion was unable to be certain that a non-accidental injury was the cause of Child R's condition. However, on further reflection the Police Report Author revised this opinion and concluded that “where non-accidental injury cannot be ruled out, an investigation should be instigated from that point” and identified this as learning for the South Yorkshire Police Service.
- 8.14 Children's Social Care's response to the uncertainty was less consistent. At times, for example when the Contact and Referral Team first passed the case through to the Duty Team for assessment, there appeared to be a similar desire for certainty but this was subsumed when they received the letter from Consultant 3. At the Learning Event it was accepted that this letter did not contain any new information and it appears that the very fact that the information was written down was the deciding factor. The hiatus in starting the s47 assessment by Children's Social Care can also, at least partially, be explained by the uncertainty as to whether Child R had suffered a non-accidental injury.
- 8.15 In discussion at the Learning Event practitioners were challenged to reflect on why they had felt the need for a definite medical opinion that Child R had suffered a non-accidental injury. It was pointed out that “uncertainty pervades the work of child protection” (Munroe 2010). The assessment the social worker undertakes is critical in contextualising the concerns, gaining an understanding and opinion on, for example in this case, the parents' parenting capacity, their experiences, support and abilities to care for a very small and unwell baby. It is this holistic assessment that puts the medical information in context and assists in forming an understanding of what may have happened, what the risks are and what needs to change to minimise those risks.

Hospitals as “places of safety”, the balance between a child's need for protection versus the need for attachment and contact arrangements

- 8.16 Viewed systemically these three themes are particularly closely linked. The (non-medical) professionals' belief that hospitals are a comparatively safe place for a child who *may* have suffered an injury impacted on their judgement about the need to arrange and manage contact. Knowledge of the importance of consistency in primary care givers to young babies also potentially affected their thinking, as did the emotive issue of a baby spending their first

Christmas in hospital. Although not specifically referred to in any agency report, staff were likely to be aware of the need to be mindful of Human Rights legislation. It was therefore particularly important that those making these decisions were aware of their own biases and had the opportunity to discuss and reflect on the decisions made. As discussed at the Learning Event, there are no right or wrong decisions in these situations – a wrong decision may be made for the right reason – but any decision needs to be made taking into account all available information, be evidenced based, and the rationale for that decision needs to be logical and articulated.

- 8.17 The use of the term “place of safety” in the Children Act 1989 relates specifically to the use of Police Powers of Protection (s46) and keeping children in a place of safety, such as hospital, when these powers are invoked. It does not formally apply to children where Police Powers of Protection are not used and is not an expression the Reviewers come across in relation to hospitals in their work elsewhere. The phrase was used in all the agency reports and therefore appears to be a “live” concept in the professional child protection system in the area. However, the discussion at the Learning Event highlighted a number of areas that meant that the safety afforded by Child R being in hospital was relatively minimal. These included the numbers of staff on duty, the fact the nursing station is not staffed all the time and is not necessarily in a central area and that, especially for a young baby, there is a risk of infection.
- 8.18 The agency reports suggested that the issue of parents' access to Child R was first raised as an issue once he was transferred to Hospital 2. As discussed above, an effective strategy discussion when the case was first referred to Children's Social Care should have considered this issue and it should have been reviewed as the situation subsequently changed. It is clear that the hospitals were persistent in pointing out the lack of supervision they were able to provide although they did not formally raise concerns through any escalation process. There was no systematic consideration of exactly what the parents' involvement in Child R's day to day care was and Children's Social Care were not even aware that they stayed overnight with him until the incident in Hospital 1 in which he was injured.
- 8.19 Interestingly Mother felt very much as though they were being watched while at Hospital 2. In discussion she was clear she understood why agencies may have felt it was necessary. What she did resent however, was the partial and what she felt to be, surreptitious and non-transparent way in which it was done. Agencies needed to be more open about their concerns and also be more creative in the arrangements they made, so that contact could be maintained, but risk minimised.
- 8.20 At the Learning Event a Children's Social Care manager reflected that her decision not to restrict contact was influenced by another case of suspected non-accidental injury where she was criticised for having separated the child from its family. Practitioners also spoke of the impact on parents of imposing supervision of contact when it has been previously unrestricted. It is likely that all of these were contributory factors in not addressing the issue more explicitly. Rotherham Safeguarding Children Board is currently consulting on a draft multi-agency protocol for children in hospital where there are safeguarding concerns which, when implemented, should assist staff in identifying the issues for consideration in these types of cases.

Communication and recording

- 8.21 The main theme regarding communication was that despite some of the strong practice evidenced by individuals and agencies, some key information was not widely available. This illustrates that practitioners were not thinking systemically and were not considering how what was going on within one part of the system informed and impacted on other parts
- 8.22 Although there were deficiencies in information sharing this was not endemic and in general, information was appropriately shared between professionals. What was more of an issue was that the implications of the information shared were not always understood by the recipients and the Learning Event exposed several instances of misunderstandings. This was clearly illustrated where there was a discussion about people's understanding of what was meant by the "possibility" that Child R had had a non-accidental injury. For some people this implied it was less likely while others understood it to mean that it was probable.
- 8.23 There were several other contributory factors that also impeded efficient communication. The fact that Child R was ill, and being subject to numerous treatments, meant a lot of medical terminology was used. This was an issue in the (handwritten) letter from Consultant 3 which precipitated Children's Social Care deciding to allocate the case, in the strategy meeting at Hospital 2 where the Team Manager struggled to record as well as interrogate the meaning of the terms used, and was a significant issue for family members who felt that much of the time Child R's condition was being explained to them in terms they did not understand. Mother said how helpful it would have been to have been given a written explanation of the terminology that was being used, e.g. subdural haemorrhage.
- 8.24 The main issue involving recording was the lack of shared written notes of strategy discussions and meetings. Although it is clear attendees made their own notes, it is essential that these conversations are accurately recorded and the record distributed to ensure that there is clarity and a shared understanding about the decisions made. The recommendations made earlier regarding administrative support at complex strategy meetings would help alleviate this but there would still remain a need for staff undertaking telephone discussions to agree the outcomes and to record them accurately.

Impact of the bank holiday on maintaining ownership and momentum

- 8.25 Initially the reviewers hypothesised that the fact Child R was in hospital over the Christmas and New Year holiday period would be a significant factor in the delays that were apparent in instituting the necessary safeguarding action. However neither the agency reports nor the Learning Event identified this as the reason for those delays. What was apparent was the weekends and holiday periods meant that there were considerable changes in the personnel involved, as shifts changed and people took leave. The fact that Child R moved to another hospital and back again compounded this. At the Learning Event the Designated Doctor suggested that there should be one key person who is contacted to ensure consistency and avoid confusion. The reviewers feel that this should always be the allocated social worker whose role is to lead the child protection investigation.

Engagement with family

- 8.26 Staff at both Hospital 1 and Hospital 2 were obviously directly involved with the family as soon as Child R was admitted to the respective hospitals. However no one from the key child protection agencies - Children's Social Care and the Police - met with them until 8th January. This was over two weeks after Mother had been told that a referral had been made to Children's Social Care. At the Learning Event the participants reflected on how this might have impacted on them.
- 8.27 At the family meeting Mother spoke very eloquently about the varying quality of interaction she had with different professionals during Child R's stay in hospital. It was salutary to realise that, for her, the main thing was not *what* was said but *how* it was said. She had felt very upset about the way she felt she was spoken to alone, and "in the middle of the night" when a decision had been made to make the referral to Children's Social Care. However, contrary to the conjectures of the Learning Event participants, she was subsequently so involved with Child R's tests and treatments that she had been distracted and did not wonder why Children's Social Care had not made contact. It was therefore very traumatic for her when four people - from the police and social care services - "marched" in to Child R's room to speak to her following the strategy meeting.
- 8.28 Mother and Maternal Grandfather' ex-partner were clear that they understood the reasons why the authorities needed to investigate and were not critical of the actions and, as mentioned above, understood the need for a degree of supervision and, at least with the benefit of hindsight, would have welcomed a more open, transparent and thorough approach about this. However Mother was scathing about the way she felt she was spoken to at critical times – notably when she was first told non-accidental injury was being considered, when she was spoken to by Police and Children's Social Care representatives following the strategy meetings at Hospital 2, and when she was told of the decision to restrict her contact following the second incident. This had particularly struck her as unreasonable and illogical as she had not been present at the hospital when the incident occurred.
- 8.29 Mother's descriptions of being "marched" up to and of being told of the suspicion that Child R had received a non-accidental injury when she was alone in "the middle of the night" were very powerful and had obviously left a lasting impression. However, her memories of these incidents were at odds with the professionals' accounts as they believed they had made efforts to make the processes less intimidating. Before the meeting with parents at Hospital 2 the Team Manager had asked the staff nurse to find them a room where they could speak to the parents and asked the staff nurse to introduce them. In the event the staff nurse stayed with Mother (the only parent there at the time) throughout the interview to provide support. Staff at the recall day accepted that Mother's memory of these events demonstrated how difficult these kinds of meetings are for parents, how unlikely it is that they will be able to "hear" everything that they are told in them. There is no right or wrong time to tell parents bad news and there is a tension between being open and transparent (and telling parents as soon as concerns arise) versus the need to time such conversations so that parents can have support from family members if necessary.

9. Conclusions and lessons learnt

- 9.1 The conclusion of this review has been that had due process been followed and a joint investigation and assessment started on Monday 23rd December (the first working day after the Hospital 1 first raised the concern that Child R may have sustained a non-accidental injury), a timely initial child protection conference held (it would have been due to be held by 15th January if Working Together procedures were followed), sufficient information would have been available to confirm that Mother was not a prime suspect for causing the injury to Child R and could have continued caring for him. This could have been under the auspices of a child protection plan and the supervision of Paternal Grandfather's ex-partner, if deemed necessary. If the investigation had started at this time it also probable Child R would not have been injured a second time.
- 9.2 The learning related to undertaking child protection investigations included the acknowledgement of the need for timely and robust strategy discussions and meetings and the recognition of the role they should have in defining the parameters of a s47 enquiry. This is as important where there is uncertainty about whether a child has suffered significant harm as it is when the cause of the harm is obvious. To be effective, strategy meetings need to be sufficiently resourced in terms of time, venue, and administrative support, as well as involving the right people in terms of both agency representatives and experience. In the vast majority of cases where a s47 enquiry concludes that the concerns are substantiated and the child is likely to suffer significant harm an initial child protection conference should be held.
- 9.3 The social worker is the lead professional in undertaking the child protection investigation while, in joint inquiries, the police are responsible for the criminal investigation. Social workers need to be sufficiently confident in their role to be able to challenge other professionals, including their police colleagues where necessary. Social workers in their first year of practice, however well supported by colleagues and managers, need to be allocated cases proportionate to their level of experience and, with the benefit of hindsight this case with its obvious complexities and uncertainties, does not appear to have been an appropriate one to allocate to an inexperienced practitioner.
- 9.4 Learning was identified regarding the concept of hospitals as “places of safety”, and regarding the necessity of balancing a child's need for protection with the need of a very young baby to form secure attachment. Staff agreed that hospitals are only relatively safe places and that professionals should challenge use of the term “place of safety”, when used in connection with a child being in hospital. Related to the need to sometimes challenge other agencies' practice, staff reflected that the Rotherham Safeguarding Children Board's escalation processes enable concerns about another agency's response to be challenged. In this case, despite misgiving about the Children's Social Care and Police response, hospital staff did not escalate their concerns in a timely way.
- 9.5 Another aspect of the learning was in regards to how safe and meaningful contact, between parents and a child subject to s47 investigation because of concerns about the parents' care, can be achieved. It was recognised that there are a number of ways of supervising contact, including the use of “safe” family members, and that systems need to be flexible and creative

to create safe, proportionate scenarios to meet individual circumstances. There are no hard and fast rules about arrangements for the supervision of children in hospital as well as an infinite number of other variables which change from case to case. For example, in this case there was discussion about when a parent should be told that there are concerns that their child might have been non-accidentally injured. The learning for staff involved with Child R was that, whatever the decision is, the recording needs to be explicit about the rationale for making that decision.

- 9.6 The importance of not only being explicit about the reasons why decisions are made but also of the need to clarify that there is a shared understanding of information was also identified as a learning point. The particular issue in this case was the amount of complex medical information which needed to be shared, and understood, so that the implications were clear to non-medical professionals as well as to the family.
- 9.7 Notwithstanding the need for medical staff to be prepared to explain terms used in diagnosis and treatment, participants at the Learning Event also commented on the phenomenon of “selective hearing” when people are in stressful and anxiety inducing situations and recognised the need to be prepared to reiterate conversations and check out that the information has been heard and understood. It is also important to put things in writing as much as possible.
- 9.8 In addition to the learning identified above the review also identified aspects of sound professional practice. These included:
- Medical professionals were alert to the possibility that Child R's condition could be, at least partially, attributable to a non-accidental injury and made the necessary referral to Children's Social Care in a timely way.
 - Hospital staff were tenacious in raising their concerns about parents' access to Child R while he was in hospital
 - The case gained momentum once the Social Worker was allocated the case and he formed a respectful relationship with Mother.
 - Extended family members were assessed to provide alternative care for Child R once a decision had been made he could not be discharged to his parents' care.

10. Recommendations

It is recognised that actions have already been made in relation to some of the individual agency's identified learning. In addition agency reports included a number of recommendations which this review endorses, with the advice that consideration is given to the comments regarding the Hospital 1's recommendation relating to discharge planning meetings. An integrated action plan which includes all of the Agency Report recommendations is attached as appendix 3.

The purpose of providing additional recommendations is to ensure that all professionals in the partner agencies of the Rotherham Safeguarding Children Board are confident in the areas identified as of concern in this review. The expected outcome of this review is that all professional working with children and families in Rotherham should:

- Be clear about their role
- Follow the expected processes

- Ensure that early discussions are held regarding the safety of a child, even when in hospital, and that these are recorded.
- Be clear about the need to start timely and sensitive assessments and investigations in cases where non-accidental injury may be the cause of a child's illness or injuries.

The following recommendations are those that the Reviewers consider the Rotherham Safeguarding Children Board should focus attention on:

Recommendation 1

That the RSCB is assured that Children's Social Care Agency Report's recommendation to review the Out of Hours Service management arrangements includes the additional expectation that the role of unqualified workers in the team should also be reviewed.

Recommendation 2

Rotherham Safeguarding Children Board should consider a review of their Child Protection Procedures and Practice Guidance due to the concerns of this review that they are incompatible with Working Together 2013 and inconsistent with Rotherham structures and arrangements.

Recommendation 3

Rotherham Safeguarding Children Board to review and update their training in joint investigations and undertake monitoring to ensure all relevant key staff have received recent training.

Recommendation 4

The Rotherham Safeguarding Children Board to request that Children's Social Care considers how administrative support can be provided to assist the chair in the more complex strategy meetings.

Recommendation 5

Rotherham Safeguarding Children Board to consider the need to develop practice guidance and training informed by legal advice and good practice to assist staff in cases where there is uncertainty about the cause of a child's medical condition.

Recommendation 6

Rotherham Safeguarding Children Board to request that an audit of s47 investigations is undertaken. The audit should be focused on cases where no subsequent initial child protection conference has been held to establish whether there is a systemic barrier to the convening of such conferences .

Recommendation 7

The leaflets available to parents/families about the child protection process to be reviewed to ensure that they are fit for purpose and that they are used consistently across agency settings.

Recommendation 8

That the Rotherham Safeguarding Children Board regularly reviews agencies' progress on

implementing the recommendations identified in their Agency Reports.

References

The Munro Review of Child Protection – Part One: A Systems Analysis; Department of Education 2010

Final Overview Report of Serious Case Review re Daniel Pelka; Coventry LSCB 2013

Working Together to Safeguard Children; Department of Education 2013

Inspection of local authority arrangements for the protection of children: Metropolitan Borough of Rotherham; Ofsted 2012