Details have been changed to protect the identity and privacy of family members and professionals involved in this case.

A professionals summary of the Management Review is available from:

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Keeping Children and Young People Safe from Harm, Abuse and Neglect

Northumberland Safeguarding Children Board

Highlighting Lessons from Management Review

Local

Date of Review: April 2009
Local Authority: Northumberland
Name: Andrew

Summary

The family became known to Children's Services at the beginning of 2008. The referral stated Cheryl and her son Andrew had moved to the area and the Social Worker questioned if Cheryl would cope with a baby without support.

An Initial Assessment was carried out within timescale following this referral and some level of need was identified by the Social Worker.

The case was subsequently closed in June 2008 and reopened in October 2008 for a further Initial Assessment following a domestic incident. Sure Start was recommended as a means of support for the family. The case was again closed in November 2008.

A referral was made via a Notification of Child Concern Pro forma from Police in December 2008 and the case was reopened. A third Initial Assessment was carried out. Not long after, Andrew was found dead in his cot. He had two old fractures but these did not contribute to his death, there is no explanation for the injuries . The cause of death remains unascertained.

The family had been known to several agencies; involvement with Health, Police and Children's Services, this was an open case at the time of death.

Lessons learned

1. Information sharing in this case demonstrated that communication could have been better between agencies. It was 'ad hoc' and not systematic.

2. It is often the case that the importance of a clear case plan for the family is not acknowledged until a case becomes 'serious'. However with the implementation of ICS this is no longer a presenting area of concern as the ICS system will not progress the referral with out a clear plan for the child.

3. When case recording is poor it is very difficult for the worker to justify what work was carried out at the time, if called to do so at a later stage. This case has highlighted that a greater emphasis needs to be placed on the importance of stringent case recording. 'If it is not written down, then the assumption made in a court of law is that 'it did not happen'. All workers need to be accountable for their own work and this can only be demonstrated through clear case recording.

4. It is essential that when assessments are carried out, the Social Worker has the ability to appropriately summarise and provide an analysis of all of the key issues in order to be able make clear recommendations for further work with the family. A checklist has been devised for Social Workers and Team Managers to refer to when checking the quality of assessments in order to ensure that good quality assessments are standard practice.

Practice / operation implications

1. Where there is multi-agency involvement with the child and family, consultation should take place with all agencies and professionals involved before decisions are made to close cases.

2. Extra consideration needs to be given to parents who present as 'uncooperative' or 'hard to reach'.

3. It is crucial that case histories and chronologies are fully analysed when a worker takes over a new case.

4. All informal supervision and actions agreed must be recorded on the child's file.

5. Fathers and any other significant family members should always be considered as part of the assessment process.