



## **NORTH YORKSHIRE SAFEGUARDING CHILDREN BOARD**

**Serious Case Review**

**Executive Summary**

**Child 'C'**

**Date of Birth – 13.07.2005  
Date of Death – 17.05.2007**

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# **1 Introduction**

## **1.1 The circumstances that led to the Review being undertaken**

The Child C was born on 13.07.05, and died on 17.05.07. Child C was being cared for at his home by a young person JC, and sustained serious head injuries and sexual assault. Child C subsequently died of his injuries, and the young person JC was convicted and sentenced for his murder. Prior to Child C's death, there had been involvement by agencies with Child C's family, and there was concern about lack of adherence to Safeguarding procedures, and inadequate information sharing. Also there had been significant concern about domestic violence matters, and the babysitting issues had not been recognised. In the circumstances, the Serious Case Review Panel considered that a Serious Case Review was required. The Chair of the Safeguarding Children Board agreed to the Review being carried out.

## **1.2 Terms of Reference**

The specific terms of reference are:

To consider the effectiveness of the involvement of agencies with the Child C's family from the antenatal period of the eldest child in the family, until the time of the death of Child C on 17 May 2007.

To consider any relevant information from the time of his birth, of the young person JC, the person convicted of the murder of the Child C.

To identify the lessons to be learned from this case in relation to the way in which local professionals and agencies worked together to safeguard and promote the welfare of Child C and his siblings.

To consider the effectiveness of agencies' handling and processes of referral, assessment, decision making and adherence to NYSCB safeguarding procedures.

To consider the approach and actions taken by agencies in respect of domestic violence referrals.

To consider the use of babysitting in this case, and the consequent need for public awareness on this matter.

To consider any practice issues arising in this Review, and how any improvements to such practice can be made.

To make recommendations as may be required setting out any desired changes, with the aim of improving single and interagency working so as to better safeguard and promote the welfare of children and young people of North Yorkshire.

### 1.3 Agencies providing reports

North Yorkshire Children and Young People's Service Access and Inclusion

North Yorkshire Youth Offending Team

North Yorkshire Police

North Yorkshire Quality and Improvement (Schools)

North Yorkshire and York Primary Care Trust

Scarborough and North East Yorkshire Hospital Trust

Tees, Esk and Wear Valley Mental Health Trust

Leeds Teaching Hospital Trust

### 1.4 Overview report writer

The Overview Report was written by Roger Thompson, who also acted as the Independent Chair of the Serious Case Review Panel. He has never been employed by any agency in North Yorkshire.

### 1.5 Family involvement

Child C's mother and father were visited independently by the Author of the Overview Report, and the outcome of the visits are included in the full report.

### 1.6 Family circumstances

Child C was the third child of a family of three children, all of whom are White British. There are features about the family life experienced by children contained in the agency management reports. In particular, the reports indicate the serious incidents of domestic violence, some of which were witnessed by the children.

## **2 Key Findings and Conclusions**

This report has not apportioned any blame to any professional for the death of the Child C, who was murdered by the young person JC. It should be emphasised also that there was no way that anyone from the families concerned or from the professional agencies, could have had any reason for thinking that such a tragedy might conceivably have occurred. There was no information or concerns about the young person JC that would have given rise to any suspicions that he might commit such a serious offence as the murder of a young child.

Child C's death has however given the opportunity for there to be an examination of agencies' practice and actions in relation to their work with Child C, his siblings, the parents and the family.

The Overview Report has identified some shortcomings in agency practice, but there is no evidence of serious systemic or institutional failings in respect of the agencies, who were involved with this Child C and his family. The agencies have acknowledged the shortcomings identified and have drawn up action plans to remedy them.

It is important in a report, which is critical of practice, also to acknowledge that there were aspects of work with the family that was positive and of a good standard. In particular, there was in general positive action by the Police in respect of domestic violence referrals.

The Overview Report has identified a significant number of incidents of domestic violence in the family, and some of these were witnessed by the children. It was necessary that such information was brought into a child protection plan. This was not done. There were also concerns about the operation of the MARAC arrangements, which primarily exist to assess the impact of the domestic violence on the victim, and provide solutions for them. The role of the MARAC in relation to child protection procedures needs clarification.

The report has addressed the terms of reference given by the Serious Case Review Sub Group, and the conclusions, lessons to be learned and recommendations contained in the report, follow on from these terms of reference and the analysis from the agency management reports.

The Report has addressed the terms of reference contained in section 5.3 above.

The report has considered the effectiveness of the involvement of agencies with the Child C and his family in the agreed timeframe.

The report has considered the relevant information of the young person JC.

The report has identified the lessons to be learned from this case in relation to the way in which local professionals worked together to promote and safeguard the welfare of Child C and his siblings.

The report has considered the effectiveness of agencies' decision-making and adherence to NYSCB safeguarding procedures.

The report has considered the approach and actions taken in respect of domestic violence referrals in the case.

The report has considered the issue of babysitting in this case and the consequent need for public awareness on this matter

The report has considered practice issues arising from the Review, and how improvements to practice might be made.

The report makes recommendations setting out desired changes so as to better safeguard and promote the welfare of children and young people in North Yorkshire.

### **3 Recommendations**

In considering recommendations arising from this Serious Case Review, the intention is to focus on a small number of key issues arising from the terms of reference. Other recommendations in the agency individual Management Reports are contained in the body of the report and are covered in the Agency Action Plans contained in the report. This is not to diminish the importance of all the matters raised by agencies, but the importance of the key recommendations is paramount. The six recommendations below are considered to be the key ones arising from this Serious Case Review. They require implementation, and should be monitored by the Safeguarding Children Board.

In making recommendations, it is important to emphasise that action has already been taken to put in hand changes identified in the Overview Report.

#### **1 Recommendation to the Director of Children and Young People's Service**

North Yorkshire Children's Services should ensure that where an Initial Assessment has been agreed on a case, it should always cover all the needs of the children within that household, and must include all relevant agencies.

#### **2 Recommendation to the Director of Children and Young People's Service**

Only in emergency situations, when a child is at extreme risk of harm or out of hours, should a strategy discussion with the Police be considered. In all other circumstances, when a child is deemed at risk of harm, a full strategy meeting must be held in order to share information between agencies and to ensure that an informed and transparent decision is reached.

#### **3 Recommendation to the Director of Children and Young People's Service**

North Yorkshire Education Services should clarify with schools the roles and responsibilities of Education Social Workers, the arrangements for referrals to the Education Welfare service, and the process for formally opening a file on a family so referred.

#### **4 Recommendation to the Chief Constable North Yorkshire Police**

North Yorkshire Police, in consultation with partner agencies, should review the operation of the MARAC system, to ensure that there is a clear procedure and policy operating throughout the County. This should include the responsibilities of MARACs, the clarity of the role and responsibilities of participants, and an agreement to a multi-agency Information Sharing Protocol.

#### **5 Recommendation to the Chief Executive Tees, Esk and Wear Valley Trust**

The Trust must ensure that where their client is a child or young person, Mental Health staff must liaise closely with other relevant health professionals such as School Nurses and Health Visitors.

6 Recommendation to the North Yorkshire Safeguarding Children Board

The North Yorkshire Safeguarding Children Board, together with the Early Years Service, should carry out a public relations exercise to reinforce to the public the differences in and requirements of childminding as distinct from babysitting, and the need for parents to take care with whom they leave their children.