Child O

01 Background

- Child O was 2 years of age and of Pakistani heritage.
- He had health difficulties which included Perinatal Hypoxic Insult resulting in 4 limb Cerebral Palsy, Epilepsy, unsafe swallow with naso-gastric feeding, global developmental delay, visual impairment and constipation.
- His condition was not considered to be life-limiting.
- He lives with his Father, Uncle, Aunt and six cousins His mother remained in Pakistan with his two siblings. Aunt was the primary carer for Child O.

02 Safeguarding Concerns

- Child O's cousins were previously subject to Child Protection Plans due to concerns of physical abuse.
- In February 2017 Child O was found to have multiple fractures with no known cause.
- He was made subject to a care order and his mother came to UK to care for him. His cousins were taken in LA care.
- Court ruled that was not enough evidence to conclude a non-accidental injury and therefore all children were returned home.
- Health professionals reported a deterioration in Child O's presentation and case was escalated back to child protection.

03 The Incident

- On 10 April 2018 Child O died suddenly and unexpectedly.
- Child O died before the Child Protection Conference could be held.
- Post-mortem reported the cause of death as unascertained.

04 The Review

- The Case Review subgroup agreed that the case met the criteria for a Serious Case Review on the basis that a child had died and abuse/neglect was suspected.
- An independent reviewer was commissioned.
- Partner agencies provided chronologies, single agency analysis reports and attended a practitioner event.
- On the advice of police, given ongoing investigation, parents were not involved in the review.

05 The Findings

- The protocol for bruising to immobile children was not adhered to.
- The role of expert court witnesses was not clearly understood by professionals
- There was a lack of professional challenge with regards the family and specifically Aunt's role and presentation.
- The threshold for Children with disabilities team is unclear

06 Recommendations

- Professionals need to better understand the court process and the role of expert witnesses in order to successfully protect children.
- All professionals must use the Greater Manchester's Bruising Protocol for Immobile Babies and Children.
- The Partnership should satisfy themselves that the thresholds for the Children with Additional Needs Team to become involved with a child are clear and robust.
- The OLSCB should address the lack of professional curiosity and challenge by professionals to families, including the understanding of invisible family members.

07 Implementing Change

A practitioner learning event is being held on 18 March at 12.30p to 2pm. Managers and senior practitioners from all agencies are encouraged to attend and will be expected to cascade the learning back into their organisations.

Oldham Safeguarding Children Partnership