both agencies went ahead on their own initiative. There was no joint approach and the safety needs of the surviving sibling were overlooked leaving him at potential risk

What are the practice implications for me?

Strategy meetings must be properly minuted and they should determine a joint working approach to S47 cases. At the conclusion of the strategy meeting all agencies involved should be clear about their roles and what action is required by them

4. When child protection enquiries extend over a weekend and involve out of hours and out of county services, it is vital that clear messages and good systems of communications are established.

What are the practice implications for me?

Professionals must ensure that there are clear lines of communication established and maintained with the Emergency Duty Team and any other agency both within Peterborough and out of county who are involved. Professionals should ensure that they are aware of the cross border protocol

A professionals summary of the Serious Case Review is available from:

Judy Jones
PSCB Policy Officer
email: judy.jones@peterborough.gov.uk
telephone: 01733 863745

PSCB/SCR03
(2009)

HIGHLIGHTING LESSONS FROM CHILD P SERIOUS CASE REVIEW

SYNOPSIS

P—aged six weeks—was taken to hospital in August 2008 with cardiac arrest. Although he was resuscitated he was found to have a fractured skull. He was transferred to a specialist hospital and placed upon life support, but due to the severity of his condition five days later the decision was taken in conjunction with his parents to withdraw life support.

He was the second child of a European Union migrant family who had arrived in the city nine months previously when his older brother was almost one year old. For the final month of his life another new arrival family with two children had shared the house.

Their stay in Peterborough had apparently been uneventful, with no evidence of concerns either about child care or adult relationships.

The only problem which came to light during the review was that they had “lost” their rent money to a “friend” from their community who did not hand it over to their landlord.

The timeframe for the SCR was unusually extended beyond the date of death to include the completion of the core assessment on the brother as this captured issues in relation to his protection such as arrangements for medicals, strategy meetings, use of interpreters and effective co-ordinated planning across county boundaries.

THE SCR CONCLUDED

“Because of the lack of previous knowledge about this family, and no evidence of any previous child care concerns or contact by professional agencies other than Health, the injuries to PS and his eventual death” from these injuries, was neither predictable nor could they be said to have been preventable by actions from professional agencies”

LESSONS LEARNED

These lessons apply to ALL agencies

1. As a result of the enlargement of the European Union and the fact that families can move freely it is conceivable that none of the services available to support families (including the police) might know of their presence in the city.

What are the practice implications for me?

Professionals must ensure that if they are working with new arrival families they inform the family of all the services and agencies that could support them

2. It is not good enough to discuss complicated and emotive issues over the telephone or face to face without an interpreter when it is not really clear how well English is understood by members of a new arrival community.

What are the practice implications for me?

Professionals must ensure that full consideration is given as to whether an interpreter is required

3. Strategy meetings should agree how the police and social care will co-ordinate their roles as part of the S47 enquiry. There was no formal meeting record and in the event