Learning Lessons Practice – Briefing Note

Serious Case Review – Child K

Wiltshire Safeguarding Vulnerable People Partnership

This briefing pulls together key learning arising from a local Serious Case Review.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice to continuously learn and develop. This document includes a feedback sheet to capture how you have used this learning.

What is a Serious Case Review?

A Serious Case Review (SCR) takes place after a child dies or is seriously injured, and where there is evidence of abuse or neglect and concerns about how agencies worked together. These locally conducted reviews aim to identify learning to improve practice, with a final report published.

More information about SCRs can be found on the SVPP website:

Learning from practice reviews

Case Summary

Child K lived with his mother and his older sibling. Their parents' relationship was on and off, and Mother had experienced domestic abuse in a previous relationship. Mother had booked late and been ambivalent about her pregnancy. Child K was born prematurely in October 2016: his sibling was one year old at this time. Child K required surgery which meant he spent almost 3 months in hospital after birth, several miles away from home, and his parents were unable to visit often.

Mother openly discussed her difficulties in bonding with Child K. She was struggling financially, losing weight and in poor health, both physically and mentally. Agencies offered support however Mother would often not accept help or act on suggestions or advice from agencies.

In December 2017, when Child K was 6 months old, a cluster of injuries indicative of non-accidental injury, including a fractured femur, were identified. As a result, Child K and his sibling were made subject of care proceedings. They were in foster care for two months but returned home following evidence in court from an expert witness, which disagreed with the original findings from the skeletal survey and stated that there was in fact no fracture.

Following the withdrawal of care proceedings Mother refused to work with Children's Social Care and the case was closed to them in March 2018, with the recommendation that a CAF be initiated to be led by the Health Visitor, with whom the family continued to have a good working relationship. This was not well communicated, and no CAF was initiated.

In June 2018, Child K was found unresponsive at home. He had been left in a room for four hours with windows and doors closed, on a very hot day. A post-mortem also revealed bruises, scratches and fractures. Both parents had had care of Child K that day. The cause of Child K's death was inconclusive.

The full report and learning can be found **here**.

Bruising and injuries in under 1s

A bruise was noticed by a professional when visiting Child K at home four weeks after his return from foster care. When Mother was questioned about it, her explanation that his sibling had thrown a toy at him was accepted.

Infants under the age of one are more at risk of being killed at the hands of another person, usually a carer, than any other age group of children in England and Wales. Non-mobile babies very rarely cause injuries to themselves and therefore must be considered at significant risk of abuse. Bruising or injuries can be a sign that parents are not coping or that they are deliberately harming their baby, both of which present significant risk of further injury. In Wiltshire most referrals for serious case reviews are in relation to under 1s who have suffered non-accidental injuries.

In response to this case the local protocol on responding to bruising and injuries in non-mobile babies and children has been updated. The Protocol sets out that all bruises and injuries to non-mobile babies and children must be reported to MASH (0300 456 0108).

The case also highlights the human factors that can distract staff from reporting a concern, for example a tendency to want to believe parents or to feel anxious about how they will react if accused of harming their child. A Leaflet for parents is now available to help practitioners explain what will happen and why all bruises and injuries in babies in Wiltshire are reported.

Learning points:

- **All agencies working with children need to be aware of the 'Responding to bruising in non-mobile babies' protocol.** Are you aware of this protocol and supported to follow it?
- **Consideration should be given to the human factors that may prevent staff from acting upon concerns so that these can be mitigated against, as far as possible.** How aware are you of the human factors that may influence safeguarding decisions, and what opportunities do you have through training or supervision to explore these?

Invisible fathers

Father was an inconsistent figure in the children's lives. Despite having contact with Child K, there is little information about him throughout the case. There seems to have been minimal professional interest in him; his relationship with Mother; his relationship and how well he had bonded with Child K and his role in Child K's care. Without this, a holistic understanding of Child K's life, and therefore the associated risks, could not be made. No agency completed a genogram, which may have facilitated a greater understanding of the wider family and provided an opportunity to ask more about Father's involvement.

Lack of engagement with fathers or significant men is a common theme in Serious Case Reviews, highlighted in the NSPCC's 2015 report 'Hidden Men'. During the case review process, participants identified some barriers which make engaging with fathers harder, for example visits routinely made between 9am and 5pm when fathers might be at work and computer recording systems which do not include space for information about fathers.

Whilst these practical challenges need to be acknowledged, flexible working practices can be employed to overcome some of them, for example evening visits or lunch break phone calls. In this case, little attention was paid to Father's role, the parents' relationship and, most importantly, the impact of this on Child K.

Learning points:

- **Practitioners should try to gather a full picture of the child's wider support network, including absent fathers and their family.** How do you gather information about wider family support and use this in your work with children and their families?
- **Agencies should always record both clear and discreet information about fathers or significant male figures. Recording should include: the nature of parental relationships, the relationship with the child, the part men play in the care of the child, and any observations about parenting capacity.** Are you encouraged to routinely seek information relating to fathers, whether absent or present? Are you able to record this information easily?

Multi-agency processes

In this case there were a wide range of agencies working with Mother and her children or offering support. However, there was no multiagency process to ensure there was a shared understanding of needs and risks and a clear action plan to improve outcomes for Child K.

In Wiltshire, the Early Help (CAF) Assessment provides a framework for sharing information and working in an integrated and coordinated way at Early Help level. The holistic assessment informs multi-agency meetings, where information is shared, and both progress and risks monitored. In this case no CAF was initiated, which meant there were no opportunities for multi-agency meetings. Reflective discussions with practitioners as part of this review have identified that this was a lost opportunity to have a more structured and evidence-based approach to understanding needs and managing the risks. The process may also have helped keep Child K at the centre of professionals' minds.

Effective partnership working could also have enabled a more holistic view of the context in which Child K lived: Mother's ambivalence about the pregnancy and late booking; the impact on Mother of two premature babies and traumatic births; and the impact of the previous domestic abusive relationship. There was no shared overview of which agencies Mother was and was not engaging with therefore assumptions were made about the level of support she was receiving.

There were further opportunities to hold a multi-agency meeting following the withdrawal of care proceedings. Local Child Protection Procedures state that an Initial Child Protection Conference could have been called when Child K returned home from foster care. However, none of the practitioners involved were aware of this expectation and so no meeting was held. Such a meeting would have provided an opportunity to re-assess the family situation, consider the risk and outstanding concerns and make a plan. This would have also enabled an agreed step down to CAF and a coordinated way forward.

Learning points:

- **Early Help procedures in Wiltshire need to be embedded, understood and followed to provide effective protection for vulnerable children. The Families' and Children's Transformation programme will lead on reinforcing the role of Early Help.** Do you understand your role and responsibilities in relation to Early Help (CAF) assessments?
- **Deciding whether to call a multi-agency meeting should be assessed based on information unique to that case, rather than on assumption of the outcome.**

Recognising vulnerability

Mother's vulnerability was identified in the ante-natal period. She had booked late and was ambivalent about the pregnancy. Appropriate support was identified at this point, however the premature birth of Child K meant that this support did not happen. Post birth, there were concerns about how frequently Mother contacted the hospital to find out how Child K was, difficulties in the relationship between Mother and Father, financial issues and housing difficulties. All these factors are likely to increase stress and can impact on parent child bonding.

Learning points:

A parent who presents as ambivalent about their pregnancy, or who does not seem to be engaged with parenthood provides an opportunity to explore with that parent their feelings towards the child and any risks that this might pose.

A Response Plan will be published shortly setting out how we are responding to the multiagency learning identified.

For more information about safeguarding unborn babies and under 1s and responding to bruising and injuries in non- mobile babies go to:

Safeguarding unborn babies and under 1s
Responding to bruising and injuries in non-mobile babies and children

For more information about Early Help: http://www.wiltshirescb.org.uk/news/families-and-childrens-transformation-programme-fact/