Kirklees Safeguarding Children Board
www.kirkleessafeguardingchildren.com

A Serious Case Review in Kirklees:

Learning Lessons (024)

This briefing has been produced to provide practitioners and managers with the key learning from cases that have been considered and discussed at the Kirklees Safeguarding Children Board Case Review sub group.

A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved and it is believed lessons can be learned from the way in which the local authority, their board partners or other relevant persons have worked together to protect the child.

Kirklees Safeguarding Children Board

http://www.kirkleessafeguardingchildren.co.uk/kirklees-case-reviews.html

What was the story?

This Serious Case Review concerns two children, one aged 13 months who, in July 2013, received life threatening and life changing head and neurological injuries (child) and one (possibly half sibling - sibling) aged 7 years who suffered neglect. The mother had learning disabilities, was prone to alcohol abuse and regularly established relationships with men with backgrounds that posed a risk to her and her children.

Background and case summary:

- Mother of the child was part of a family known to agencies with three generations of alcohol abuse and domestic violence prevalent
- Mother suffered learning disabilities with very poor literacy and had previously attended a special school
- The mother's life was generally chaotic and characterised by movement between authorities, habitation with various family members and associates, alcohol-induced anti-social episodes but with short spells of settled behaviour patterns exhibited
- Mother had a conviction in 2010 for a serious assault
- Various known partners of the mother were characterised as having mental health issues, alcohol and drug dependency and a tendency to violence and offending behaviours. Mother had 4 known partners of this description, with Partner 4 being associated with mother at the time of the child's injuries.
- Whilst living in a previous authority the sibling had been the subject of a Child Protection Plan for neglect and care proceedings had been considered
- At transfer to Kirklees there was clear evidence of mother's vulnerability particularly to her being impulsive and gravitating too easily to others, and her history of being vulnerable to dangerous relationships
- At pre-birth assessment, the extent of the mother's learning disability remained unidentified and her perceived compliance was disguised at that time by her positive outlook, positive behaviour patterns and her pleasing demeanour which led to a view from CSC workers that this was an 'easy' case
- In December 2012, the case was stepped down from Child Protection to Child in Need and this process was characterised by a lack of clarity on agreed behaviours and outcomes and an over-optimistic view of the case that did not identify the historical issues and complexities.
- In March 2013, the case was closed to the Multi Agency Support Team however, on-going monitoring of the sibling's experiences by the school was not set up and there were process delays which meant that new concerns and referrals were sent to the wrong part of the CSC system
- Between May and June 2013 there were re-emerging concerns and referrals however lack of clarity over the status of involvement of different agencies meant that information and evidence about the sibling's poor state of health and life experiences was missed

Overview and Analysis

Strengths and Protective Factors

School was a constant reference point for the sibling and they held information and background on the family that was useful

Risk/Harm/Danger

Mother's learning disability was undiscovered and could not therefore form part of the case context

Mother's perceived compliance led agency workers to believe that behaviours were changed despite evidence to the contrary

Mother's cyclical negative behaviour - association with inappropriate partners, was not picked up by workers as a regular, repeating pattern

Grey Areas

Due to the mother's learning disability, it was not clear whether she really and fully understood the risks she was taking in choosing particular partners

Complicating Factors

Capacity of CSC was not always sufficient to deal with changes in the case in a timely and thorough enough manner (staff and management shortages and periods of sickness)

Voice of the Child

There are examples of the sibling being asked to contribute their wishes and feelings and of these being recorded

Analysis

This case is characterised by:

- an over-optimistic view of the mother's understanding and compliance
- lack of clarity about the exact involvement of different agencies particularly at step-down points
- Lack of clarity from all agencies over expected behaviours and outcomes necessary from the mother with clear contingency planning
- Deterioration in the sibling's health and well-being failing to trigger escalation

Conclusion

- This case was complex and involved much good social work practice
- An underlying thread throughout this case was an incremental progression towards an unrealistic perception of the family - and of the risks posed to the children – by the professionals involved
- Reflective analysis of the case history may have helped to show the behaviour patterns and the seriousness of the risk. A focus on individual episodes rather than case overview by agencies hindered day to day decision-making
- Resourcing issues and consequent excessive workload had an impact on the capacity of individual professionals at key stages
- The frequency of, and the quality of recorded management oversight and supervision impacted negatively
- Inter-agency working (particularly at step-down) became muddled with a lack of clarity about who was doing what, when and why
- Much of the focus was on working with mother and the voice of the child and particularly the daily lived experience of the child/children did not receive sufficient attention

Relevant Tools & Multi-Agency Responses for this case include:

- Disguised Compliance links
- Learning Disability Protocol links
- Chronologies and genograms training as an assessment tool link
- Good Practice with Assessment and Plans link
- Case Closure processes link
- Practice Standards and Management and Supervision Model link
- Reflective Supervision Approach link
- Guidance for HVs and GP practices on information sharing link
- CAADA Dash risk assessment link
- Resolving Professional Disagreements link

Learning for Professionals and Multi-Agency Working

- Assiduous and regular management oversight of cases and quality of practice is of paramount importance and should be scheduled and always carried out as planned; Management oversight should always include challenging of assumptions and perceptions; Regular, high-quality supervision of individual practitioners needs to be a priority for managers, scheduled and always carried out as planned
- Regular use of and reflection on chronologies and genograms as part of assessments
- The school experience of both parents and children should be included in assessments

For more information about Serious Case Review and this case visit:

http://www.kirkleessafeguardingchildren.co.uk/kirklees-case-reviews.html

'Closing the loop'

Actions taken to address the learning

What has improved/changed as a result of the actions taken and how do we know?
What have the audits revealed and what has happened since?
What metrics have been presented in reports and what are the continued trends that are demonstrated?
Are we assured that learning has been embedded across all agencies?

Evidence of impact of these actions

How often is the evidence reviewed?
What happens if the evidence indicates no improvement or little improvement or things slipping back?