Kirklees Safeguarding Children Board
www.kirkleessafeguardingchildren.com

A Serious Case Review in Kirklees:

Learning Lessons

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?

On 30th September 2013, an 18½ week old baby girl died unexpectedly whilst in the care of her parents. There were no siblings. Mother was a teenager described as 'vulnerable' and father was a former Looked After Child. The child was found to have suffered multiple injuries probably over a three-month period including serious head injuries although the exact cause of death was not established through post mortem examination.

Background and case summary:

- Mother of the child was not known to CSC, father was a former LAC and so was known and was visited regularly and appropriately by the Personal Adviser.
- There was regular and appropriate involvement from health and leaving care agencies throughout the pregnancy and the post-natal period. The Family Nurse Partnership and GP were lead agencies in this case.
- Parents presented the child at hospital accident and emergency services once for stool irregularities and she was kept in overnight due to bruising on the cheek and leg. Referral was made to CSC D and A by a paediatric consultant who accepted the explanations from father and no further action was taken.
- Police visited the family home twice, once during the pregnancy and once when the child was three months old, both times at the request of the mother who stated on both occasions that she wanted to leave the family home, however she changed her mind on both occasions and the police did not see any evidence of physical violence. No DASH assessment was completed and other agencies were not informed of these incidents.
- Mother was never seen alone and consequently there was no formal assessment of the potential for domestic abuse.
- Parents of the child initially attended all appointments with health professionals, however three months before the death of the child this changed and appointments were missed and/or postponed.
- There was a 9 week period before the child's death when she was not seen by health professionals although the family home was visited regularly.

Overview and Analysis

Strengths and Protective Factors

There was consistent and regular contact between appropriate agencies and the parents.

The Personal Adviser understood and acted well on his responsibility to pass on important information to other agencies.

Risk/Harm/Danger

The child was not seen by the main agency contact (FNP) for a period of 9 weeks – half the child's life.

During the pregnancy, and after the child's birth, the mother was never seen alone, always with her partner.

Police involvement with the parents, due to reported DA were not linked together to indicate a pattern and were not communicated to any other agencies.

Grey Areas

Specialist teenage pregnancy midwifery service was not available to the mother and this may have determined the extent of the mother's vulnerability.

In the absence of CSC involvement for the child, there is no formal and prescribed mechanism for orchestrating the case and pulling all the different agency information together.

On completion of the Leaving Care service involvement with father there were no prescribed ways of CSC supporting the father and the family

Complicating Factors

Organisation structural change and retirement of key individuals led to lack of adherence to procedures and standard practice and quality of case management.

Family Nurse did not receive tripartite supervision with named safeguarding nurse and did not seek 1:1 supervision with this specialist team-member because there were no perceived safeguarding concerns.

Systems in health for linking electronic records from different agencies were not available.

Voice of the Child

The voice of the child could not be heard due to her age however the child's experiences could be deduced from visible signs. There were relatively long periods where the child was not seen by any medically qualified agency staff.

Analysis

This case is characterised by:

An initial period of full and productive engagement by the parents followed by a period of avoidance.

On presentation at hospital, the consultant paediatrician's acceptance of the explanation of non- accidental bruising on a non-mobile infant

Assumptions made by FNP nurses about the controlling character of the father which led to non-compliance with process.

Conclusion

This case involves a family that did not present a perceived high risk and so there were limits on the involvement of agencies. Family involvement with the lead agency (Family Nurse Partnership – FNP) is on a voluntary basis and in order to continue with the support it was necessary for FNP staff to be accommodating to the family member's wishes and not to properly question or interrogate their behaviours or motives.

There were opportunities for more involvement from Children's Social Care that were missed and that might have led to a different outcome for this child because this would have led to a more orchestrated, structured and team-around-the-family approach. Failure to complete a pre-birth assessment was one missed opportunity; failure to complete a DASH assessment was another; failure to register non-accidental bruising on a non-mobile infant as a trigger for further investigation was another.

The child was not seen by a health professional for 9 weeks, however without acknowledging the additional risks that the above opportunities would have triggered, there was inadequate emphasis placed on this and the voluntary engagement of parents with FNP further diluted this emphasis.

Communicating important and relevant information within and between agencies was a significant factor in this case. Who knew what and when led to incomplete analysis and oversight by professionals and inhibited effective decision-making.

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

- FNP Guidance notes on assessing DA/DV and 'Relationship Assessment Form'
- Bruising, Burns and Scalds Protocol

Learning for Professionals and Multi-Agency Working

- Co-ordinated communication between and within agencies is something that requires regular analytical review.
- Assumptions made about the character and behaviours of adults cannot replace adherence to agreed protocols and guidance.
- Professional curiosity and scepticism should be encouraged at all times and in all cases.
- Inherent vulnerability is recognised and acted upon equally with vulnerabilities perceived through current presenting behaviours and attitudes.

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?