Kirklees Safeguarding Children Partnership

A Serious Case Review in Kirklees:

(Child B & C)

This briefing has been produced to provide practitioners and managers with the key learning. A Serious Case Review (SCR) takes place after a child 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.

What was the story?
This review is in respect of twin girls born five weeks prematurely in November 2017, they are known as child B &C. Both girls suffered physical injuries six weeks after their birth. This included multiple fractures detected through a scan. The family were not unknown to agencies given a familial concern about neglect and its impact on two other children in the household.

Background:
This family was well known to services in Kirklees. Louise was known to have had a very poor childhood experience, witnessing domestic abuse between her parents as well as experiencing the impact of her father's poor mental health and her mother's substance misuse. Louise has a learning disability, which is recorded on several agency records, although any formal diagnosis of this and the specific impact it has on her ability to process and understand information is less clear. Louise did not engage well with professionals working with her about the concern for her children. It is likely that for much of her own childhood her parents had sought to avoid interaction with professionals and encouraged her to do the same.
In September 2017 a pre-birth assessment was commenced in relation to the planning for the arrival of B&C. This was not completed nor were any interim findings presented to the multi-agency partners working with this family. In October 2017 a Child Protection Review meeting was held, the minutes concluded that there has been "lots of improvements". There was no evidence that Louise herself had changed her parenting style. It was this meeting that agreed that the unborn twins would be placed on a child protection plan because of risk of neglect.
One week following the Child Protection Review meeting, the decision was made that the twins could be returned to Louise's care, following their hospital birth. This plan was shared with health services. Despite records suggesting the pre-birth assessment was to be completed, this was not actioned, nor is there evidence that a full discussion with multi-agency colleagues took place.
In the two weeks prior to the premature birth, home conditions deteriorated leading to an emergency core group being held on the 27th November. There are no minutes of this meeting however the original decision to return the children post birth to Louise's care was implemented, suggesting that multi-agency contingency planning was weak.
At the time of their six-week developmental assessment by the GP, there was concern regarding the poor weight gain of one of the twins which was referred to the Heath Visitor for follow up. There were no symptoms of fractures or bruising on either of the babies.
Two days later Louise took one of the babies to hospital in the early hours, concerned about bruising on her face. A scan revealed the existence of fractures and consequently the second twin baby was examined, and evidence was found of multiple fractures also.
Both children and their older siblings were subsequently all taken into the care of a local authority.

Overview and Analysis

Strengths and Protective Factors

- Other partner agencies sharing their concern
- Mum`s sister and friend

Risk/Harm/Danger

- Insufficient information on mum`s childhood and the impact this could have on her children
- Mum`s lack of engagement with professionals
- Lack of completed assessments including pre-birth
- Lack of information sharing
- Reliance on mum being compliant

Grey Areas

- Professionals did not fully understand mum`s learning difficulties.
- Professionals did not investigate dad`s background further
- Professionals understanding the balance between healthy scepticism while maintaining a relationship
- What was the relationship like between the parents

Complicating Factors

- Mum`s adverse childhood experience and her learning disability
- Scaling methodology is open to perception

Voice of the Child

- Views of the older children were not incorporated into the decision-making process.
- Missed opportunities to not only hear hat children were saying but to listen to them

Analysis

- Professionals to be more curious and ask questions around parental background, had this been done with mum additional support could have been offered in relation to her disability and provide assurance over the support being provided.
- Information sharing between agencies could be improved, including the completion of all assessments.

Learning for Professionals and Multi-Agency Working

- The need to recognise the impact of parents own history and Adverse childhood experience on parenting capacity
- The importance of effective multi agency pre-birth assessment in informing planning
- The need for Kirklees to develop a strong and robust response to Neglect
- Recognising and avoiding over optimism
- Understanding how difficult it is for a parent who has negative experiences of professional involvement to accept help
- The need for all agencies to effectively escalate concerns in a proactive way
- The importance of a strong and effective leadership at all levels to drive practice improvement, this includes supervision of front line staff.

For more information about National Reviews and learning visit:
https://www.gov.uk/government/groups/serious-case-review-panel

https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/national-case-review-repository/

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

- Pre-birth assessment tool
- Neglect Practitioners Toolkit
- Working with Parental Learning disability Good Practice Guidance

For more information about Local Reviews and this case visit: https://www.kirkleessafeguardingchildren.co.uk/safeguarding-2/safeguarding-processes-and-systems/safeguarding-practice-reviews/