Learning Lessons from a Serious Case Review

A Serious Case Review (SCR) is undertaken when a child dies or is seriously injured where it was known or suspected that the child suffered from abuse or neglect. This briefing has been produced following an SCR into a child who had lived for most of its life in Bradford Metropolitan District but died in another area in 2017. Therefore frontline staff and managers from Bradford agencies were involved in the case review.

The briefing summarises and highlights key learning points from the case, and is aimed at front line practitioners, managers and organisational leads. The briefing focusses on the way in which organisations or professionals worked together to protect the child and includes positive practice, lessons learned and how services can further improve.

Despite the commitment and efforts of the practitioners working with the family this child was living with multiple risks, was displaying signs of distress and died in tragic circumstances. Some of the serious injuries suffered by this child were non–accidental and the learning from this SCR emphasises what changes may be applied to help partner agencies better respond to vulnerable children in the future.

What was the story?

The Child lived at home with mother and over a period of time, a number of her partners. The Child's mother had experienced familial sexual abuse and was a looked after child from a young age. Mother's siblings were also removed from parents following physical abuse. Mother previously lived with a Foster Carer with whom she developed a supportive relationship. Her father was known to agencies as a risk to children and although he should not have had unsupervised contact with any child; she continued to have contact with him when her child was with her.
The Child was living at home with mother, mother's boyfriend of short duration and a male friend at the time of death. The cause of the Child's death was not ascertained at the point that this Serious Case Review (SCR) began.

Background:

The Child was born with a medical condition which required regular attendance at medical appointments and specialist interventions in hospital.
When she became pregnant, mother was offered intensive support from specialist agencies in the area in which she was living. She engaged with one service in particular, but this became less consistent when she started new relationships and also due to frequent moves.

- The Child of this SCR underwent a Child Protection Medical whilst a resident in Bradford and four more the following year whilst living in the new area.
- The first time was during a routine medical when a professional noticed bruises on several parts of the Child's face and body - mother reported that the Child bruised easily. A subsequent child protection medical determined that the bruises were likely to be accidental injuries.
- There was an un-witnessed fall reported to the hospital by mother resulting in a visible injury to the Child's forehead which was assessed and no treatment required. Mother's partner was present who was the third partner seen with mother since the Child's birth. This partner was reported to be aggressive with staff and had to be removed from the hospital ward by security. Mother later disclosed that the bruises were caused by her ex-partner, following this she separated from him.
- A short time later, mother attended hospital with the Child and a new partner who was aggressive to hospital staff and had to be escorted off site.
- On another occasion, a burn was seen on the Child's hand which was reported to Children's Social Care by a concerned party.
- Mother moved to be nearer to her birth family. She also suffered a miscarriage at this time and was reported as struggling to cope with the loss. She subsequently separated from her partner.
- Later the Child attended hospital (Emergency Department) after reportedly falling down a flight of stairs. Bruising was noted to the face and eyes and a left conjunctival haemorrhage. A Child Protection medical was undertaken following safeguarding concerns raised and child protection procedures were followed.
- 2 additional medicals were undertaken following observations of new bruising and concerns expressed by staff working with the Child and inconsistent explanations of new bruising reported by mother. Extended family offered alternative explanations for each of the bruises and marks. Children's Social Care convened a professionals meeting to ensure everyone was working together and that the Child stayed safe and well
- Shortly afterwards a decision was made to hold a Strategy Discussion with the police, with the view to convene an Initial Child Protection Conference. Although there was no definitive evidence to suggest the bruising was caused deliberately there were increasing levels of concern from both Children Social Care and Children's Centre professionals on the number of presentations in such a short time frame. The child protection conference was arranged quickly however the Child died before the meeting took place.

Overview and Analysis

Strengths and Protective Factors

Mother's supportive long-term relationship with her previous foster carer;

Involvement with a specialist agency and persistence of the Practitioner who provided continuity, intensive support and with whom she engaged for some of the time;

A referral was made to a service to assess parenting and support around behaviour issues for the Child;

Children's Centre staff appropriately raised concerns and shared information;

A full assessment was undertaken and an Initial Child Protection Conference was planned.

Complicating Factors

Assumptions that engagement with a specialist agency meant issues & concerns were addressed

Insufficient understanding/assessment of the significance of mother's childhood history/ impact of trauma on her behaviours, relationships, ability to parent

Moves across borders meant information was not shared, especially as this was not at 'child protection' level.

The child being 'easily bruised' due to underlying health condition was ruled out by paediatricians but tested for again as this information was not shared.

Risk/Harm/Danger

Unexplained bruising to the Child indicates lack of supervision or inadequate parenting.

Mother reported physical abuse by partner

The Child's emotional needs were placed secondary

Impact of mother's childhood history on her ability to parent effectively

Different males introduced to the Child and into the home in quick succession

Mother disengaged from services at times of crisis - indications she 'couldn't cope'

Different practices/ service provision/ information sharing cross boundaries

Professional optimism

Frequent moves of address and disengagement with agencies

Mother's partners demonstrated aggressive behaviours and at least one was implicated in an injury to the Child but they were not involved in assessments/planning and were illusive to services

Voice of the Child

Professionals did not always consider what life was like for the Child

Grey Areas

Unknown relationships between mother and her partners; and the men and the Child

Unknown impact of frequent changes of partner on the behaviour and development of the Child

The relevance of mother's past history of abuse when making judgments and decisions about the current situation and impact on her parenting capacity.

Unknown cause of death

Inability to clarify whether injuries were non-accidental

Unknown events occurring during periods of disengagement with services (including new relationships with unknown men)

Analysis

At times, professionals were over optimistic, e.g. mum made positive decisions about one partner but this may not have been to protect her child.

There was a lack of professional curiosity about family relationships, including mother's partners; the number of injuries noted; what prompted disengagement with services.

Insufficient attention was given to understanding the 'lived experience' of the Child

Agencies did not share information cross borders when Mother admitted she had previously lied about how the Child received injuries.

Learning for Professionals and Multi-Agency Working

- An historical allegation of child abuse where the child continues to live in the same situation must be responded to following safeguarding procedures. The mother alleged that an ex-partner carried out the abuse and did not protect the child at the time. Therefore when a parent/carer provides a false report, professionals should be particularly curious about any further injuries or unexplained bruising
- Agencies in the area where the child was fatally injured did not know about the admission of alleged abuse, therefore professionals who hold relevant safeguarding information have the responsibility to pass to others who share concerns, regardless of geographical areas and even when not at child protection level.
- West Yorkshire Interagency Procedures chapter 1.4.40 and Bradford Information Sharing Guidance should inform the actions to take when families move across local authority boundaries and specifically where there have been recent child protection concerns.
- Where parents don't engage with services, it may mean that a child's needs are not being met or that risk is increasing; professionals need to be proactive, and ensure actions meet the Childs Timescale (i.e. if it is safe for the child to remain in the family the Non Engaging Pathway should be used as appropriate).
- When agencies intervene with families the aims, expectations and desired outcomes should be clearly articulated. Plans should be child centred and outcome focussed, SMART and highlight clearly what will happen if sufficient progress is not made within the child's timescale and expected outcomes are not achieved. If necessary refer to Resolving Multi agency disagreements and escalation procedure