Oxfordshire Safeguarding Children Board

Learning from the Serious Case Review for Child Q

Summary:

This case concerned a 14-month old child who died, as the result of drowning, having been left unattended in the bath. The child is referred to as Child Q in order to protect her identity.

Child Q lived with her mother and an older half-sibling. At the time of Q's death, both children were subject of a Child Protection (CP) Plan, due to significant concerns about neglect and parental inability to protect them from harm.

Child Q's mother had a difficult personal history, and there was little consistent support from her wider family, whereas Q's father and paternal relatives were involved in regular 'respite' care for Q. The family received a good level of support from a range of professionals.

The concerns about Mother's ability to care for her children centred around her immaturity, her (poorly understood) level of drug and alcohol misuse, her periodic depression, and her exposure of the children to unsuitable teenagers and adults. There was a large network of universal and specialist services working with the family, with Children's Centres taking a prominent role in 'teaching' parenting skills and monitoring the children's care. However, Mother was an inconsistent user of services, and found it hard to sustain any improvements. She moved twice in the children's early years, with her last move placing the family in a more isolated situation. These moves meant that relations with professionals were broken and had to be built up again.

Findings:

- The Child Protection Plan for Neglect did not consistently spell out the specific risks to the children and the consequences if the desired outcomes for their improved safety were not achieved.

- Professionals were not consistently and sufficiently pro-active in response to incidents and allegations regarding the children, based on their perception that they 'didn't have enough evidence' to pursue the incident.

- A delay in the process and timeliness of robust handover between professionals group when the family moved resulted in interruption of the knowledge about the family and the case, and lead to unintended 'start again' for the new professionals.

- The input and cooperation of the mother, was prioritized at the expense of not engaging the other parent (father) in the child protection process.

- The commitment to working in partnership with parents in Oxfordshire inadvertently led to an assumption that professionals could not meet together, without parents being present, when they had concerns regarding case management.

- A delay in timely and consistent sharing of CP plans and minutes.

- There was no agreed use of a multi-agency tool to capture a chronology of significant events, this made it more difficult to assess risk to the children and parental patterns which demonstrate poor capacity to change.

Key areas for improvement:

- Challenges in dealing with inconsistent and neglectful parenting
- Professionals' lack of curiosity or challenge in relation to self-reported explanations of harm to the child/ren
- Need to involve fathers better as a protective factor
- Loss of continuity of service (and records) when families move across boundaries

Themes in common with other reviews:

- **Parental neglect** - challenges faced by professionals working with vulnerable families where neglect is an embedded issue.
- **Fathers/male carers** – communication with and involvement of fathers and male carers and the importance of thinking carefully about the role of the father in the family system.
- **Parental mental health** – the impact of the parent's mental health problems on the safety and wellbeing of the child.
- **Substance abuse** – understanding of substance misuse and interventions, the changing levels of risk, and the impact on the child.

Learning points for practitioners: Think Child

- Assessments: Always make an assessment of what a father or male partner and his family can offer to a child (positives), as well as of the risks he or they may pose.
- Responses to incidents: Ensure that you speak to a child alone in relation to any allegation of harm or physical signs of harm and follow Child Protection procedures. Escalate concerns and be confident in following up to confirm your concerns have been heard.
- Communication: Always share information about allegations of harm or physical signs of harm with the allocated Social Worker for the child.

Learning points for managers

- Management: Ensure that neglect cases have clear plans – with desired outcomes, timescales, etc. – which are reviewed robustly on a regular basis, taking account of new evidence and increased risk.
- Risk assessment: Review the risk assessment after any incidents to ensure that it reflects and addresses ongoing concerns.
- Supervision: Ensure that reflective supervision is carried out in neglect cases, with a focus on the lived experiences of the child/ren.
- Tools: Promote the use of chronologies as a vital tool in tracking progress in neglect cases.
- Training: Support (and expect) practitioners to undertake training for responding to neglect and physical injury.

Key messages for inter-agency learning

- It is vital to share information about any physical marks to a child with your safeguarding lead and with the allocated social worker. Ensure your discussions are recorded and be confident to chase up as necessary.
- Agencies should feedback to Children's Social Care when they do not receive minutes of formal meetings (CP Conferences and Core Groups, and Strategy Meetings) within the required time.
- Any professional from any agency can request a professionals meeting without a parent being present if there is a need to do so.
- In relation to **neglect**: *Practitioners need to have an open mind about the possibility of neglect having a fatal or very serious outcome for a child but deal with neglect cases in a confident, systematic and compassionate manner.'*[1]
- The Neglect Toolkit (and all the lessons from the Neglect pilot) should be widely embedded in practice across agencies.
- Ensure that neglect is not accepted and normalised when working with families.

Time to reflect…

Stop and think – is the risk assessment robust and being regularly reviewed? Is the child protection plan up to task and is there evidence that it is making a difference to the child?

Analyse and assess the risks that arise when a vulnerable family moves across boundaries and all professionals change: risks include loss of knowledge and understanding of the family; loss of professional relationships with the mother and children, and among the professional network; the risk of 'start again' syndrome.

[1] Brandon, M., Sidebotham, P., Bailey, S., Belderson, P., Hawley, C., Ellis, C., Megson, M., *New learning from serious case reviews: a two year report for 2009-2011*, Centre for Research on the Child and Family in the School of Social Work and Psychology, University of East Anglia Health Sciences and Research Institute, Warwick Medical School, University of Warwick, 2013, p.82

Did you know……..

Please click the links below for resources available:

- **OSCB Audit Summary document** Working with fathers
- **OSCB Neglect Toolkit**: http://www.oscb.org.uk/wp-content/uploads/Child-Care-and-Development-Checklist-for-use-in-neglect-June-14.doc
- **Action for Children, Research in Practice** and the **NSPCC** have come together to produce a document exploring the potential relationship between neglect and forms of sexual harm and abuse – 'Child neglect and its relationship to other forms of harm – responding effectively to children's needs'
- **Multi-agency safeguarding procedures –** The OSCB multi-agency procedures cover a wide variety of situations you may encounter. You can access them at http://oxfordshirescb.proceduresonline.com/
- **Pathways to Harm, Pathways to Protection: A Triennial Analysis of Serious Case Reviews 2011-2014' published May 2016:** http://www.oscb.org.uk/wp-content/uploads/Triennial-Analysis-of-SCRs.pdf
- **Seven Golden Rules for Information Sharing –** Professionals should familiarise themselves with the golden rules for sharing information. There is a downloadable flyer available on the OSCB website: http://portal.oxfordshire.gov.uk/content/publicnet/other_sites/oscb/documents/professionals/Neglect/7_Golden_Rules.pdf