Five Recent Serious Case Reviews

Summary

During September five serious case reviews (SCRs) were published which attracted considerable media attention. These were amongst the first SCRs to be published in full on high profile cases. The cases were Daniel Pelka (Coventry), Keanu Williams (Birmingham), Child T (Haringey), Child D (Portsmouth) and Maisie Harrison (Northamptonshire). Daniel Pelka and Keanu Williams were murdered by their carers, Child T concerned repeated serious injury to the child, Child D and Maisie Harrison were Sudden Unexplained Death in Infancy (SUDI) with co-sleeping a contributory factor in a context of neglect.

While each case has unique features the accounts given by the SCRs have much in common with each other and with the conclusions of the overview studies of SCRs by Marion Brandon et al (New learning from serious case reviews: a two year report for 2009-2011. Brandon et al Research Report DFE-RR226).

In each case there were weaknesses in:

- Social work assessments;
- Multi agency assessments such as prebirth assessments;
- The child's view and the child's experience were not central to the practice or consideration of the case;
- Rules of optimism and tendency to start again with each incident or new engagement with the family applied;
- Key information was not shared across the professional network involved with the child and family;
- No one had a full picture of all the circumstances of the child and their family;
- Domestic violence, drugs or alcohol misuse or psychological problems were features of these cases; and
- In nearly all cases there was evidence of resource and organisational, capacity and capability problems in key social care, police and NHS agencies.

The overview reports make a number of recommendations to address the issues in each case and the individual management reviews make numerous recommendations for their agencies. The SCRs recognise and reference previous SCRs which have made similar findings and the reviews of SCRs by Marion Brandon et al. In that sense there is little new in these SCRs in terms of practice recommendations or policy developments. They reinforce the centrality of good individual and collective safeguarding and child protection practice and that this needs to be good across all the agencies.
It is very evident from these cases how weaknesses in one agency need to be picked up by other agencies and practitioners and challenged. Where there are weaknesses across the safeguarding system then failure to identify and accurately assess risk of harm to children is significantly increased.

The SCRs deal to varying degrees with wider “why” questions including why findings are repeated from previous SCRs. They all in some degree give information on the local context for the agencies involved. The critical factors arising across a number of agencies, other than those mentioned above, appear to have been:

- Inexperienced staff and staff lacking the competence and confidence to deal with very complex family situations;
- Management instability and lack of effective management oversight;
- Difficulties in keeping track of families moving around frequently; the need for consistency of professional contact;
- Loss of investigative thrust where there had been injuries and the medical opinion of their cause was uncertain;
- In some local authorities and community health services, serious staffing issues leading to staff shortages, frequent changes of worker and use of agency staff;
- Peripheral role of GPs and the weak links between GPs and social workers and in some cases health visitors;
- Lack of clarity about what the plan is for the child and family and consequently what success will look like;
- Lack of challenge between and within agencies;
- Staff taking a narrow view of their responsibilities and not taking a wider view of their role and whether they needed to share information or act on information which they had;
- Lack of challenge and scepticism about what the adults say about events and their behaviour i.e. domestic violence, drug and alcohol consumption;
- Lack of consideration of history on a single or multi-agency basis leading to an overoptimistic view of the child’s circumstances.

Finally these SCRs bring into sharp focus the role of Local Safeguarding Children Boards and their function. This has led a number of the LSCBs involved to reflect on their effectiveness and impact given these reviews show evidence that in spite of much activity at Board level there remain serious weaknesses in practice across the local interagency safeguarding systems.

**Daniel Pelka – Coventry**


Daniel died in March 2012 aged 4 years and 8 months. He died from a blow to the head but had suffered months of serious neglect and abuse prior to his death. He had been systematically deprived of food, fed salt, locked in a room and physically abused.
He had numerous injuries at the time of death as well as the head injury which was the cause of death. Daniel’s mother and her partner were convicted of his murder. Daniel had an older and younger sibling. The family were Polish.

The SCR identified three key points were intervention could have made a difference. These were:

- When Daniel had a broken arm in January 2011 the medical assessment was inconclusive but there were concerning features to the injury and its presentation. The recommendation was for a core assessment. This was undertaken but did not focus on the injury and its background and the long history of domestic violence. The assessment did not lead to any intervention with the family;

- Daniel’s presentation in school, which Daniel started in September 2011, as always hungry. Daniel was observed scavenging for food and was stealing other children’s food. His mother said he had health problems and the school sought help from the family GP and the school nurse referred Daniel to the community paediatrician. In addition school staff noticed a number of injuries to Daniel on his head and neck which were not explained. These were not linked to the eating problems and did not lead to any onward referral or other intervention;

- An appointment with a community paediatrician in February 2012. This examination linked his low weight and eating problems to a likely medical condition and did not consider emotional abuse and neglect as a possible cause of Daniel’s weight loss.

A feature of this case which is absent from the other four cases is the extent to which Daniel’s mother and her partner deliberately set out to deceive those professionals they had contact with. This was evident in the history they gave at the paediatric appointment and to the school in respect of Daniel’s eating problems. They also consistently downplayed the extent of alcohol abuse and domestic violence in the family.

Domestic violence and alcohol abuse were a prominent feature of this case. There were twenty seven reported incidents between 2007 and 2011 most of which were responded to promptly by the police. However the follow up was inconsistent, with not all reported to either NHS or social care services. The domestic violence screening process was not working effectively. There was inconsistency in follow up actions from the screening and lack of consideration of the impact on the children of the full history of domestic violence and the mother’s difficulty in separating herself from violent men or avoiding starting new relationships with another violent man. The ending of one violent relationship was seen as resolving the matter.

While there were a number of social care assessments undertaken between 2008 and early 2011, assessments by health visitors and the paediatric assessment in February 2012, at no point was there a multi-agency discussion of the family which might have brought together all the information available. Such a consideration might have led to exploration of why Daniel was identified as the child with a problem in this family. His siblings were adequately cared for and this appears to have made it more difficult for those in contact with the family to see the neglect and abuse that Daniel was suffering.

The social care assessments did not adequately consider the repeated history of domestic violence associated with alcohol abuse by Daniel’s mother and her successive partners and the likely impact of this on the children, especially when its cumulative effect over time is considered. There was a tendency to start again and not seek verifying evidence about what the adults were saying about their behaviour e.g. whether they had stopped drinking which the historical evidence would have suggested needed to be treated with scepticism.

In the various assessments by all the professionals involved Daniel was not visible and his and his siblings’ experience and perspective not given weight. This included failure to use interpreters to help engage Daniel and his older sibling so their voice could be heard.
The SCR identified weaknesses in recording practice across the agencies and in the schools which reinforces the need for detailed and accurate record keeping as the basis for good information sharing and accurate assessment.

The recommendations from the SCR focus on:

- Ensuring that the domestic violence screening process is effective;
- Referral and assessment in children’s social care and in particular that this engages other agencies and provides feedback to them;
- Training in identifying neglect and emotional neglect;
- Assurance that school systems for recording and considering injuries to children are in place;
- Monitoring of the implementation of the development of health visiting and the implementation of the healthy child programme;
- Medical staff considering child abuse as a differential diagnosis where there are unclear concerns;
- Use of interpreters.

**Keanu Williams – Birmingham**


Keanu Williams was two years old at the time of his death in January 2011. He died of multiple injuries to different parts of his body. He suffered several major injuries over a period of days before he died. His mother was convicted of his murder and her partner of cruelty to a child. His mother and the adults involved in his care are white British.

The SCR concluded that “professionals in various agencies involved had collectively failed to prevent Keanu’s death as they missed a significant number of opportunities to intervene and take action.”

Keanu’s mother had had a long involvement with Birmingham Children’s service and was still receiving services as a care leaver at the time of Keanu’s birth. Keanu’s older siblings were born while their mother was still of school age. There was no pre-birth assessment of these children. Both were premature babies who were vulnerable. They were subject to child protection plans in 2005 and 2006 but the recommendations from those plans were not implemented. They were removed from the child protection plan in 2006 when they were living with their maternal grandfather, and their mother and father were not expected to resume their care. The significance of this for Keanu was that the lack of analysis and good quality assessment at this time meant that there was not a good enough background history available for future reference. For example one of the siblings had suffered a burn and Keanu also suffered a similar burn with similar explanation of causation offered.

Keanu’s mother led a very unsettled life and moved to Torbay from Birmingham. Her vulnerability was recognised in Torbay when she was pregnant but the recommendation for a specialist pre-birth assessment was not implemented and superseded by a parenting assessment completed in May 2009. Keanu and his mother were in a parent and child placement and moved to supported lodgings prior to moving back to Birmingham.
A good core assessment was undertaken in November 2009 and presented to a child protection conference. The conference concluded that the case be managed as a child in need with a Common Assessment Framework undertaken by a children’s centre. There was no subsequent work on Keanu’s mother’s parenting capacity and the focus was on practical support.

The school Keanu’s siblings attended expressed concern in October 2010 and subsequently but the school concerns and the concerns about Keanu were not connected. This was seen as an opportunity to review the whole family which was missed.

Keanu had four accident and emergency attendances between June and November 2010 for injuries. These were considered due to neglect and there was no consultation between children’s social care and the police with the GP, health visitor, family support service or the nursery. There was no assessment or care plan made in response to these events. Keanu was seen for his two year development check in late December 2010, and in early January 2011 he presented as distressed at nursery with injuries. His distress and the injuries were not acted on and he died on 9 January 2011.

The SCR identifies the key themes as:

- A lack of focus on the children in the family – what Keanu’s experience was;
- Lack of confidence to challenge;
- Starting again and professional optimism not based in assessment of the history and current circumstances;
- The need for proactive questioning and challenge and review of information and reassessment to reflect new information;
- Information sharing in practice and that this needs to be used as an opportunity to have a conversation;
- The importance of collaboration within and across agencies to help bring a whole family system view and to avoid parallel working of professionals;
- The importance of collaboration on assessments and that there needs to be mutual challenge in developing assessments;
- Being side-tracked by the need to attend to practical matters.

The recommendations from the SCR focus on the need for Birmingham Safeguarding Children Board and its constituent agencies to focus on their core business as expressed in the LSCB guidance and regulations. To this end there is a recommendation to review their core child protection business with a focus on the child’s journey. Other recommendations include:

- Improving access to records within each agency;
- Multi-agency audits to track that agencies have records of strategy meetings, core groups and child protection conferences;
- Interagency review of CP medicals;
- Tracking and review of new service models to ensure that action is taken to safeguard children;
- Training based on a current needs analysis;
- Organisations to provide evidence of action taken to address individual and management practice which has fallen below expected professional standards.
Child T – Haringey

The full report is available at: http://www.haringeylscb.org/child_t__full_serious_case_review_overview_report-2.pdf

Child T was born in 2007 and suffered serious injuries in the summer of 2010 and in February 2011. On both occasions he was returned from hospital to the care of his family and subject to further abuse. A SCR was undertaken because of the reoccurrence of abuse and the lack of protection afforded to this child.

Child T and all the adults involved in his care are Polish. Child T has three siblings: child V who is a full sibling aged 2 years, and child W aged 7 years and child Y aged 6 months who are half siblings. (Ages are at June 2011).

Child T’s mother came to England in 2009 leaving her children in Poland with their maternal grandmother. The children joined her in March 2010. Mother entered a relationship with Mr C who is the father of child Y.

In June 2010 child T was brought to hospital with bruising around the eyes, forehead and nose and other bruising on the body. The family said he bangs and hits himself. The hospital referred their concerns to a neighbouring local authority who took no action. This was not the correct local authority for the family address. Child T was removed from the hospital by the family and the child referred correctly to Haringey. A strategy meeting was held which led to police and children’s social care visiting. The children were spoken to using an interpreter and said they were not abused. The Paediatrician remained concerned and wrote to social care. This letter was not acted on. Action was to complete a core assessment and subsequently to close the case after writing to other agencies.

Child T was seen by the family GP with bruising on two occasions. The GP offered a choose and book appointment with a paediatrician to consider the bruising further. The mother and stepfather did not follow this up.

In February 2011 the plan was to close the case following a discussion of what other support is available to the family between the social worker, health visitor and family support services. Within days child T’s mother alleged violence to child T and her from her partner, Mr C. Child T was found to have extensive bruising - over 50 bruises. A strategy meeting was held and care proceedings initiated. Child T was returned to his mother’s care. A week later further bruising was found and it was concluded mother and maternal grandmother were likely to have caused this bruising.

The SCR identifies the following issues:

- Lack of escalation within the hospital when child T first presented and hospital remained concerned about the social care response;
- Mr C was an intravenous drug user and had presented as self-harming and this information was not linked to the children in his household;
- Flawed assessment which did not take adequate account of the concerns of the paediatrician and was too ready to think the injuries were accidental and did not explore the wider family background and history. This was not a borderline case of child abuse. The social care work subsequently focused on practical support and away from the original reasons for the intervention. This meant the investigative thrust of the work was lost and it moved to family support;
- Limited consideration in supervision in social care - only once in seven months and lack of managerial challenge;
- Following the second set of serious injuries too positive a view of the family, e.g. mother and maternal grandmother, was taken;
• Significant staffing issues in the responsible social work team with changes of manager and budgetary and political pressures at the time;

• Within the health visiting services a failure to follow up as an enhanced level of need case, problems in their recording system and caseloads dominated by complex and chronic child protection cases;

• GPs repeatedly failing to consider the possibility of non-accidental injury in the family and lack of communication with the health visiting service;

• Mr C’s known history of drug and alcohol misuse not considered in terms of its implications for the rest of the family;

• Weaknesses in collaborative working – lack of cross referencing and communication across all the relevant agencies e.g. school, social care, GP, health visitors, drug and alcohol services;

• Lack of focus on child’s experience and point of view;

• As Mr C was the only family member able to communicate well enough in English, the world was interpreted through his view.

The SCR reflects at some length on this case happening so soon after the high profile case of Peter Connelly and reflecting some of the same issues. It also comments on the picture of organisational change and disruption, workload pressures and staffing and budgetary pressures which are evident in a number of the individual management reviews.

Because the events reviewed in the SCR were not recent, the SCR sets out issues arising from the review which the Haringey Safeguarding Children Board might wish to be reassured on rather than recommendations. These include:

• Is the quality assurance of decision making in child protection cases sufficiently resilient?

• Are escalation processes sufficiently understood?

• Are staff clear about availability of specialist support such as the named doctor for child protection?

• Are information sharing arrangements robust enough?

• Are supervision arrangements systematic and robust enough?

• Are there the resources and organisational stability to meet their child protection responsibilities?

• Is there a need to reinforce awareness of domestic violence?

• Do gender-based assumptions about who are the likely perpetrators of abuse need to be challenged?

• The voice of the child was not heard or their experience adequately considered.
Child D – Portsmouth

The full report is available at: http://www.portsmouthscb.org.uk/user_controlled_lcms_area/uploaded_files/Child%20D%20Overview%20FINAL%20190913.pdf

Child D died aged three weeks in December 2011. The inquest determined that the child died of natural causes and was a sudden unexpected death in infancy. An SCR was undertaken as the child was subject to a child protection plan and care proceedings, there were longstanding concerns about four half siblings of child D, the child had been left at night in the care of a vulnerable young woman who was the child’s aunt and there were indications that the agencies involved had not always worked together effectively. Child D and all the family members are white British.

The SCR covers the period from 2005 to 2011 because of the need to consider the care and support given to the four older half siblings, child E born in 2005, child G born in 2007, child F born in 2008 and child H born late 2009. In December 2008 child F presented with bruises to the head and other unexplained medical conditions. The father of the children was implicated and this led to a child protection plan. The plan, with which there was poor compliance, ended prior to the birth of child H in late 2009. In January 2010 child H had bruising and on examination was found to have eleven rib fractures, a broken ankle and possible compression fracture of the spine.

All four children were placed within the family and care proceedings were initiated.

Mother and a new partner sought care of all the children in early 2011 and mother was pregnant again in May 2011. A pre-birth assessment was started on mother and completed in November 2011 but did not include the baby’s father.

The care proceedings on the four older children were concluded with residence orders to the family members who were caring for the children. This followed confusion on the part of the local authority as to what their plan for the children was. Relationships between the local authority and the family carers were strained.

When child D was born the local authority plan was to initiate care proceedings and seek placement with foster carers. Mother had care of the child in hospital. When the matter came to court there was an agreed care plan with an interim supervision order to maternal grandmother until a contested hearing could take place. A written agreement was in place but made no reference to the part Ms J, aunt, would play in the care of the baby. She was part of the maternal grandmother’s household.

The SCR identifies a range of weaknesses in practice including:

- Social care assessments not placing injuries in context and responding to recent events without looking at the wider perspective, and the pre-birth assessment was single agency;
- Health visitors not including any analysis about the impact on the children of their circumstances in their developmental assessments;
- Muddle over care planning for the older children and the status of the family carers;
- Drift in case management in social care;
- Weak legal support;
- Inexperienced workers handling a very complex case without sufficient management support and oversight;
- NHS services not addressing mother’s repeat pregnancies;
• Focus on adults and not considering how far adult problems and risk had an impact on the children;
• Lack of challenge, and passive approach to case management within CAFCASS;
• Lack of a shared perspective being achieved with the family.

The SCR recommendations include:

• Multi-agency quality assurance work to establish how well agencies work together;
• Safe-sleeping initiatives;
• Reviewing progress from a previous SCR which presented similar features to this case;
• Strengthening work between schools and children's social care;
• Strengthening legal services;
• Improved arrangements for pre-birth child protection concerns;
• Greater senior manager oversight of the progress of cases in care proceedings.

Maisie Harrison – Northamptonshire

The full report is available at:
http://www.lscbnorthamptonshire.org.uk/user_controlled_lcms_area_screlated_files/Maisie%20Harrison%20Overview%20report%20for%20publication.pdf

Maisie was just a few weeks old at the time of her death in May 2012. The post mortem could not ascertain the cause of death though co-sleeping was considered a contributory factor. Maisie was the subject of a child protection plan for neglect at the time of her death. Maisie died in her mother’s care while at her mother’s partner’s flat. The flat contained clear evidence of drug paraphernalia and Maisie had severe nappy rash. The partner was Maisie’s father. This was contrary to the child protection plan which specified Maisie was to sleep at maternal grandmother’s home. Maisie and her parents were white British.

Both Maisie’s parents regularly abused drugs and alcohol. They both have some level of learning difficulty. Maisie’s mother, who was eighteen at the time of Maisie’s birth, had a very troubled history at school where she had made disclosures of substance abuse and of sex with older men. These were not followed up by her school through referral to other agencies. Maisie’s father was thirty two at the time of her birth and had a conviction from 2001 for grievous bodily harm to a child who was six years old at the time and the child of his then partner.

There were multiple risk factors at the time Maisie’s mother booked her antenatal care, already late in the pregnancy, in January 2012. An initial assessment was undertaken with a child protection conference held shortly after Maisie’s birth. She was born four weeks premature. There was no full pre-birth assessment which considered all the risks including the father’s history of harm to a child.

The child protection conference did not lead to any clear contingency planning. It was a reactive plan and not focused on the risks the parents posed. The plan was to discharge Maisie to the care of her mother at her maternal grandmother’s home but without clear expectations set as to the grandparent’s role.
Significant concerns were expressed by a housing officer who saw Maisie with her parents in early May which were not responded to.

The SCR concluded there was clear evidence of the risky behaviours of both parents. They both had histories which identified them as vulnerable individuals who would have difficulties successfully parenting. The review concluded “There was insufficient timely investigation, enquiry and a lack of professional inquisitiveness and challenge to Maisie’s parents. There was too high reliance on looking at immediate positive evidence rather than considering the longer term outcomes which could have been predicted given the lengthy history of difficulties which both parents had.”

The SCR recommendations focus on:

- Need for a specific procedure for child protection cases involving an adult who poses a risk to children;
- Pre-birth and parenting assessments and the need to ensure these are expedited and that each pregnancy is considered afresh;
- The need for critical and questioning practice;
- The importance of child protection plans with clear and measurable goals;
- New incidents of likelihood of or of significant harm need a strategy meeting and be investigated under S47;
- Review of school child protection procedures so that concerns are referred appropriately.

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