Serious Case Review

Louise

Executive Summary

Serious Case Review in respect of	Louise
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EXECUTIVE SUMMARY

1. Introduction

1.1 This case review focuses on the serious injuries which were sustained by Louise in June 2019, who was 18 months old at the time. The injuries caused had a life changing impact on Louise. When the injuries occurred, Louise was being cared for by her mother's partner at the mother's address. Prior to the incident, there were concerns about domestic abuse and child neglect.

1.2 This review was commissioned to examine the circumstances of this case and, by involving those most closely involved in it, to understand if there are areas from which learning can be elicited to improve services and reduce the potential of harm to children in the future.

1.3 This report was published more than two years after the review was completed due to waiting for parallel processes to conclude. Due to the timeframe involved in publishing the report and to reduce the risk of re-traumatising the family, the Herefordshire Safeguarding Partners are publishing an Executive Summary of the report only.

2. About the Author

2.1 The author in this review is Jonathan Chapman, he has no prior involvement with the case and is not connected to any of the agencies involved. He is a retired senior police officer, who had responsibility for strategic and operational safeguarding and was a senior investigating officer.

3. Terms of reference and methodology

3.1 This review was commissioned under the statutory guidance provided by Working Together 2015. This guidance allows Local Safeguarding Children Boards to determine their own processes for review. The Case Review Sub-Group of the Herefordshire Safeguarding Board decided that the review would be undertaken by agencies involved providing Individual Management Reports (IMR) and a chronology of their involvement. This information would be enhanced by facilitated practitioner discussions.

3.2 A scoping exercise was conducted to understand which agencies should be consulted and included. The time period agreed for the review was June 2018 to June 2019 with any relevant background information outside of this period being made available to the review process to support learning and improvement.

3.3 Each identified agency was asked to research their information, and where necessary interview key staff, and to prepare a chronology and Individual Management Report (IMR).

3.4 There then followed a practitioner discussion at which professionals, managers and IMR authors gathered to discuss the case.

3.5 Based on the reports and discussions the overview author compiled this report, which was then subject to another practitioner discussion to enable the development of the learning and recommendations which flowed from the analysis.

3.6 The below agencies and staff were involved in the information sharing and discussion event.

- Herefordshire Children Social Care
- Early Help Herefordshire County Council
- Herefordshire and Worcestershire Clinical Commissioning Group
- Warwickshire and West Mercia Community Rehabilitation Company
- 2gether NHS Foundation Trust
- Education
- Children Centre
- West Midlands Ambulance Service University NHS Trust
- West Mercia Police
- Worcestershire Health Care NHS Trust
- Worcestershire Children Services
- Wye Valley NHS Trust
- Local third sector provider

4. Learning points identified from this case

4.1 One of the factors which impacted most significantly on action taken, or not taken in this case, relates from the ability for the wider context of a case to be considered. Referrals and information received were often considered in isolation, instead of looking at the wider context of the safeguarding concerns and the factors that were impacting on the children. The connection between two families was overlooked and the common denominator, the mother's partner, was not taken into account.

4.2 When assessing the impact of domestic abuse, and there are children involved, there should be a focus on the children and the impact the abuse has on them. Consideration should be given to all preventative and protective tools such as DVPN and MARAC. Consideration should be given to the cumulative effect of domestic abuse.

4.3 Information was submitted to an agency professional in the MASH and there were instances when the information did not move past the agency representative when what was needed was a referral to CSC. There appears to be more than one pathway for information to be received and recorded, which should be addressed.

4.4 Safeguarding children is very important for all adult focussed services, they need to be reminded of adherence to their policies and where necessary to refer to their named safeguarding professional.

4.5 The cumulative effects of neglect, and in particular emotional neglect linked to domestic abuse, needs to be a focus for professionals. The work to recognise and effectively assess neglect, embedding the Graded Care Profile should continue to be a focus.

4.6 Where there are new partners in families there should be appropriate assessment of the risks that they may present.

4.7 There continues to be a need to impress on practitioners the need to be more professionally curious. To not accept information on face value and to try to check and triangulate information where possible.

4.8 All information should be assessed against what is known, anonymous information should be given credibility until the necessary checks have been put in place to verify or negate it.

4.9 Schools are integral to the safeguarding of children; they know the children and families better than most organisations and are able to provide a real insight into the lived experience of the child.

4.10 There is still a reluctance to challenge decisions which are not considered to be correct. Where practitioners do not agree with decisions, they should work to resolve them with reference to Herefordshire Resolution of Professional Disagreements Policy.

4.11 There should be more awareness of the potential signs and symptoms of abusive head trauma in infants and interventions focussed on preventing them.

5. Recommendations

5.1 In February 2020, The Safeguarding Children and Young People Partnership in Herefordshire (SCYPiH) Safeguarding Partners Board and Quality and Effectiveness Group hosted a workshop chaired by the Partnership Independent Scrutineer. This group comprises of senior leaders from agencies involved in safeguarding. The author presented this and another case, which has similar themes. The Scrutineer and author worked with the group to identify themes and resulting actions to address the learning identified in this review. This process has assisted in achieving joint agreement, understanding and collective responsibility of the identified areas of learning and development.

5.2 The areas of recommendations were classified as following:

- The partnership improvement priorities for SCYPiH Partnership.
- Key areas of partnership activity that SCYPiH should seek assurance on.

- Any matters that need to be brought to the attention of and/or addressed by other strategic partnerships.

Identified learning opportunities

5.3 The agreed priorities will form part of the new partnership strategic plan and the partnership will be held to account by the Independent Scrutineer, Quality and Effectiveness Group and annual reporting to ensure that the areas are addressed.

The partnership improvement priorities for SCYPiH Partnership.

1. **Framework of need and pathways –** To ensure that there is a joint understanding and agreement in the application of thresholds of all levels of need and that referral pathways are clear and understood. That both Child in Need and Child Protection Plans and processes are robust, outcome focused and clearly understood and owned by all agencies.

2. **Multi Agency Safeguarding Hub –** to develop one access point, that there is robust and consistent management oversight. That the functions are collaborative and there is a clear and understood collective responsibility. To ensure that information is effectively shared to make effective and safe decisions including in domestic abuse cases.

3. **Neglect –** The multi-agency responsibility to identify and respond to all aspects of neglect. To include educational and emotional neglect and the effects of non-dependent alcohol use by parents and the impact of these on children.

Key areas of partnership activity that SCYPiH should seek assurance on:

1. Application of thresholds, to be undertaken by multi-agency audit.
2. Escalation and professional disagreement policy.
3. Neglect.
4. Safeguarding of children in mental health services.

Any matters that need to be brought to the attention of and/or addressed by other strategic partnerships.

1. Domestic Abuse Strategic Board/ Community Safety Partnership Board – to ensure that MARAC and other interventions such a Domestic Violence Prevention Orders are understood and embedded. That the impact of domestic abuse on children is understood and prioritised. That there is a greater emphasis

on working with and managing offenders. That there is a greater understanding and recognition of same sex domestic abuse.

Identified learning opportunities

1. Training on the cycle of change and motivational interviewing.
2. Escalation and professional disagreement.
3. Recognition and prevention of abusive head injury in infants.

Additional

There were also a number of single agency actions that were identified in this review and the completion and progress on these will be overseen by the SCYPiH.

6. Changes implemented during this review

6.1 The engagement of agencies in this review has been very positive, there has been a real demonstration of agency reflection to enable learning.

6.2 The GP practice have held two internal learning events as a result of this case and their engagement in the discussion events for this process was excellent. As a result of internal discussion, they have introduced a template of safeguarding prompt questions which are asked when any adult presents with low mood, depression or is prescribed anti-depressant medication. This was recognised as good practice and should be communicated to other GP practices.