



Practice review report: Keanu Williams

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularly around multi-agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

The events leading to the serious case review took place in January 2011. An ambulance was called because Keanu was said to be having breathing difficulties. On arrival at the home address, CPR was commenced by the paramedics attending. Keanu was taken to hospital at 8.05pm and was pronounced dead at 8.35pm. Further examination revealed that Keanu had multiple injuries to different parts of the body. The ambulance personnel notified the police. The cause of death was determined as multiple injuries. The injuries were determined to be the result of separate incidents with several major injuries being sustained over a period of days.

Circumstances of, and challenges faced by, the individual

At the time of Keanu's death, his mother, Rebecca Shuttleworth, was still deemed to be a care leaver having spent her childhood and teens in receipt of services from children's social care, health and education. She experienced periods of time placed in foster care subject to care orders, on more than one occasion, and section 20 (of the Children Act 1989) periods of accommodation. On two separate occasions in 2005 and 2006, child protection concerns were reported about the siblings and enquiries took place, which led to the children becoming subject of child protection plans. The referrals included injuries and a burn from a radiator at a very young age.

What happened?

Rebecca Shuttleworth was convicted of Keanu's murder and of cruelty in respect of one of his siblings. She was sentenced to 18 years in prison. Her partner Luke Southerton was also convicted of cruelty to a child. He received a nine-month suspended sentence and was ordered to carry out 200 hours of unpaid community work.

Why it happened?

The main finding set out in the serious case review was that professionals in the various agencies involved had collectively failed to prevent Keanu's death as they missed a significant number of opportunities to intervene and take action. They did not meet the standards of basic good practice when they should have reported their concerns, shared and analysed information, and followed established procedures for Section 47 enquiries (child protection investigations) and a range of assessments, including medical assessments and child protection conferences.

The serious case review panel was in agreement that Keanu's death could not have been predicted. However, in view of the background history of Rebecca Shuttleworth and the older siblings, including the lifestyle and parenting capacity of Rebecca Shuttleworth, and the vulnerability of Keanu in Rebecca Shuttleworth's care; it could have been predicted that Keanu was likely to suffer significant harm and should have been subject of a child protection plan on at least two occasions to address issues of neglect and physical harm



The overview author and the serious case review panel concluded that there were a number of significant missed opportunities to provide services to the three children and to assess their needs within a collaborative multi-agency framework. Services should have been provided to promote the welfare of the children on a number of occasions as they were clearly children in need and on several occasions services should have been provided to safeguard them from significant harm.



Report recommendations

The serious case review makes eight recommendations:

- Birmingham Safeguarding Children Board (BSCB) should review child protection to focus on the “child journey”, and “key facts” should be readily available to frontline staff
- agencies should review the access that staff have to records
- BSCB should ensure records are sent to relevant people and filed properly
- there should be a “critical review” of child protection medical assessments and support procedures
- BSCB must track and review the process of any changes
- procedures for “whistle-blowing and challenging” to be reviewed by all agencies involved in the case
- new training programmes for staff
- there should be a management review to provide evidence that action has been taken.

Citation Lundberg, B. (2013) *Serious case review in respect of the death of Keanu Williams: born 11 December 2008, died 9 January 2011* [full overview report]. Birmingham: Birmingham Safeguarding Children Board.