Children XXX

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularity 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 review looks at circumstances around an eight-month-old baby who died in the spring 2017. There were no injuries and it is believed that he died prior to his arrival at hospital. The baby is the mother's sixth child. In 2012 four older maternal siblings were removed from their parents care due to domestic abuse. Of these four, the two younger siblings were adopted during the scope of the review. The two eldest siblings were in foster care, the very eldest child often returning to the family home.
There were two local authorities involved in this case (LA1 and LA2).

The mother was assessed as having a personality profile with a number of impulsive, sensation seeking behaviours that may be erratic and/or unpredictable. It was not classed as a personality disorder.

Circumstances of, and challenges faced by the individual

- The baby and his sister were sharing the same bed as their mother. The mother had received advice about co-sleeping but there may not have been enough emphasis around the risk factors of drug use (including prescribed drugs and alcohol) particularly when discussing co-sleeping with children, as the professionals appeared unaware of alcohol use at this time.
- The mother reported that the father of the sixth child had minimal involvement with the family.
- After the death of the baby, the mother revealed that the father was an alcoholic.
- The mother admitted after her first four children were removed from her care, she drank four cans of alcohol daily. After the death of the baby, she drank eight cans daily.
- The family were moved several times and there were six changes with health visitors (some were due to staff changes).

What happened?

- The mother's personality traits were not shared with health. There was no evidence that health was invited to a child protection conference at LA2.
- None of the agencies involved with the family knew or suspected the alcohol use by the mother.
- In early 2015 the fifth child was moved from a child protection plan to a child in need plan. It was felt that a public law outline would provide sufficient protection.

- There was a lack of clarity regarding the mother's psychological assessment. Some professionals thought that the mother has a personality disorder. Others shared professional anxiety of not knowing significant information which meant that their decisions could have been different. Details of the psychologist's report were not shared beyond LA1.

- The midwife contacted the LA2 Information Access and Advice service to flag up that the mother was pregnant with her sixth child, due to significant history of local authority involvement. There was no record from health of this conversation for reasons unknown. LA2 did not record this as the contact did not proceed to an actual referral, therefore there is no need for them to log this.

- Some of the professionals did not understand terminology used regarding the status of the case at key points and felt it was 'confusing'.

- Prior to the scope of the review, both Child 1 and the mother were arrested at the grandparent's home. South Wales Police widely shared the incident but Child 5 was not identified and cross-referencing was not robust enough across agencies.

- Health professionals had concerns about Child 1 regarding domestic abuse. Mother had stated he had caused damage in the home, was depressed and angry, and at times using new psychoactive substances (NPS). This was not shared with other agencies.

- There were minimal enquiries made about the mother's relationship with her new partner and not much known about the quality of the relationship, its level or the quality of contact with the children given the mother's vulnerability and previous abusive relationship.

Why it happened?

- The list of names of people attending the child protection conference also include a Flying Start health visitor. It was not clear if the copy of the minutes were shared with health as the box was blank.

- The decision to move the fifth child to child in need was not challenged by the independent reviewing officer/conference chair.

- The decision had an impact as LA2 had to withdraw from a Public Law Order (PLO) process as the threshold was not met, therefore a Care Order no longer existed. All professionals felt that a PLO would have a protective factor. However, none of the professionals seemed to appreciate that the removal of the child's name from the Child Protection Register would undermine the PLO process.

- LA1 did not share regular information about the first two children with LA2, therefore LA2's decision making around Child 5 was not fully informed.

- LA1 did not share information with LA2 regularly as they would only share anything significant. The review felt that the information should be shared regularly, and the onus was on LA2 to decide what to do with the information i.e. take action or ignore.

- The psychological report of the mother was not shared by LA1 with partner agencies. The report was about the mother's ability to work with agencies and not sharing information would have impacted how the mother could work with the agencies.

- Some professionals did not fully understand their statutory duty at key decision-making points.
- There were some assumptions that it was not necessary to share information with other agencies as they already knew about the domestic violence and Child 1.
- There had been little consideration on the impact of either having Child 1 living in the home or being a regular visitor on the younger maternal siblings.
- During the learning event it was clear that practitioners had different views and understanding about the need for consent to make enquiries with other agencies if the child protection threshold was not clear.
- The mother mentioned a 'partner' and due to the turbulent nature of the relationship it was not easy to establish if this referred to the father of the sixth child or another man. At key points, she was not asked to provide a name, there was a missed opportunity for professionals to assist in establishing the identity of the men in her and her children's lives.
- The child in need plan's closure summary was not shared with partner agencies. The outcome of parenting work was also not shared with partner agencies.

Report recommendations

The serious case review makes eight recommendations:

1. Guidance to be developed to help children's social care staff to work better with their colleagues from other local authority areas, particularly in cases where members of the same family reside in more than one area.
2. Significant information about parents known to one agency should be shared with other agencies working with that family where there are historical or current child protection concerns. All conversations held with children's services should be documented in the child's records – even if the outcome of the conversation is no further action.
3. Detailed information about the different legislation should be included in child protection training.
4. All Police Protection Notices (PPNs) should be completed in full, including details of children or vulnerable adults in the home and all efforts should be made to ensure full detail is recorded at the time of the incident. All agencies continue to have a responsibility to cross-reference details with their own records.
5. There were concerns expressed by professionals at the learning event about making enquiries ithout consent when the threshold for child protection was not clear. What is important is that families are advised of the expectation placed on practitioners to share information when practitioners and circumstances consider it is justifiable (as per Laming, 2003 – Victoria Climbie Inquiry at 1.46 of his report).
6. Practitioners need to be clear about family structure and seek information about all adults involved with a child and to consider the type, level and quality of contact and care.

7. A letter to professionals highlighting future changes which would be likely to raise further concerns would be helpful when cases are closed.

8. Frontline professionals should receive regular training so that they understand the key messages on the prevention of unexplained sudden infant death. Co-sleeping advice should be further reinforced after baby reaches six months, particularly with respect to risk factors.

Citation

Warlow A, and Baker A. (2018): Western Bay Safeguarding Childrens Board

www.safeguardingboard.wales/2018/11/29/western-bay-concise-child-practice-review-362017/