Serious Case Review
6 Step Briefing
Child Ap

The Background

Child Ap died shortly after her first birthday. She had sustained a significant injury to the brain – life support was turned off after her condition sadly deteriorated.

Safeguarding Concerns

Child Ap lived with her mother, mother's new partner and siblings. There were historic concerns relating to domestic abuse between the children's parents and the children's emotional well-being (father was and continues to be in prison during the time period considered in this review). Mother's partner, a young male with a troubled childhood, was the main carer for the children during the day whilst mother worked.

The Incident

Child Ap was in the care of her mother's partner at the time of the incident. Mother had left for work. Later that morning she received a call from her partner advising Child Ap was not responding having fallen off a bed. Mother called 999 on her way home. A subsequent scan identified Child Ap's extensive injuries were not consistent with the explanation given.

The Review

The Independent Chair of the NSCB made the immediate decision to undertake a Serious Case Review following a discussion with the Director of Children's Services following the death.
A multi-agency Panel was convened, along with an Independent Chair and Independent Author to undertake the review. The review sought to develop an holistic and systemic perspective in understanding Child Ap's life and the circumstances of her life and death.

The Findings

- The GP Practice discussed the family at multi-disciplinary meetings. The children's records contained extensive information which would indicate the children were subject to neglect, however, this was not communicated with Children's Social Care.
- Midwifery clinicians responsible for mother's care through her pregnancies had escalated their concerns to Children's Social Care and Health Visitors appropriately.
- Health professionals missed an opportunity to refer Sibling 1 to Children's Social Care following three presentations to A&E in one day for head injuries, however, concerns were escalated using a Paediatric Liaison Form.
- There is a history of 'Was Not Brought' to health appointments.
- Mother was reluctant to engage with a professional unless she had initiated the contact.
- The Health Visitor was aware of the history of the family and offered additional support although mother declined this. Once she became aware of mother's new partner, she appropriately shared with partner agencies.
- The Chair of the Initial Child Protection Conference overruled the majority view of those in attendance to make the children subject to Child Protection Plans, however, subsequent changes in allocate Social Worker then led to some drift and delay in following up progress and issues of concern.

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The Findings

- The Child Protection Plans appeared to focus on re-integrating the father into the family rather than being focused on the children. Given the degree and severity of domestic violence in the home, the disguised compliance on the part of Mother and the emotional abuse and neglect which the children had experienced, this view was over optimistic.
- The Child Protection Plans were stepped down to Child in Need despite a lack of visits to the home and children not being seen.
- It is evident mother's partner was a vulnerable and troubled young person when he became a looked after child. He was difficult to engage and frequently went missing which meant it was difficult to assess his behaviour and wellbeing. Insufficient attention was given by professionals to understand the reasons for his persistent episodes of being missing.
- School played a major role in supporting Child Ap's siblings and teachers demonstrated a real understanding of the children's anxieties, however, not all their actions, despite the good intention, were always in the children's best interests. Various concerns were dealt with by speaking with mother rather than escalating to Children's Social Care.
- There was one incident where police were aware of mother's new partner living in the family home and that they were aware he was a prolific offender and drug dealer, however, they did not submit a Police Protection Notice to Children's Social Care.
- Subsequent police intelligence was submitted to the 'front door' but was not progressed to MASH (Multi-Agency Safeguarding Hub) as the information was single strand and could not be corroborated.
- BeNCH held considerable information about mother's partner, however, it was not shared with agencies.

Key themes

- **The need for information sharing to support holistic assessment.**
- **Disguised compliance and non-engagement.**
- **Lack of focus on the children.**
- **Assessment of significant male's adults in the lives of children.**

Recommendations

Recommendation 1:

- The Northamptonshire Safeguarding Partnership needs to be assured that all agencies involved in child protection processes work together so that there is focus on the needs and wellbeing of children, and that the interests of children are the first priority of professionals. This will be achieved by the Safeguarding Partnership undertaking a multi-agency audit, with external scrutiny.

Recommendation 2:

- The Safeguarding Partnership will remind all agencies involved in Child Protection and Child in Need Processes of the vital importance of sharing all information known to them in order that a holistic assessment can be undertaken of a family. This will include the requirement to be mindful of the need for professional curiosity, (including the arrival of a new partner in a family) which is embodied in thorough assessment processes, rather than consideration of episodic events, which can lead to disguised compliance on the part of parents being missed. This may necessitate the need for the provision of further professional training.
- The Safeguarding Partnership will seek assurance from all agencies involved in Child Protection Conferences that when a representative cannot attend and a report is sent on behalf of the agency, a process is in place whereby receipt of the report is acknowledged.

Recommendations

Recommendation 2 continued:

- Where Police and/or Probation intelligence is shared with other agencies about the risks presented by the behaviour of adults to children this needs to be investigated to ensure that children are safe.
- Partner agencies will ensure that a Strategy Meeting needs to be convened when there is Police intelligence and/or where it is believed that drug dealing is taking place within a household where children are present.

Recommendation 3:

- The Safeguarding Partnership will consider providing a programme of training to all partner agencies on the importance of recognising disguised compliance on the part of parents.
- The Safeguarding Partnership will undertake multi-agency case audits to assure itself that agencies are fully utilising the Northamptonshire Graded Care Profile when assessments are made.
- Where cases are not progressing, the importance of reflective supervision and challenge needs to be emphasised and reinforced.

Recommendation 4:

- The Safeguarding Partnership will assure itself that the seriousness and significant risk of cannabis misuse on the ability of a parent/carer to care and safeguard their child is fully understood by all professionals by providing training which emphasises the risk of parental cannabis misuse to children and the potential impact on them.
- Reviewing the Threshold Assessment Framework so that cannabis use is included.
- Undertaking a local media campaign to raise awareness of the risk and impact of misusing drugs and alcohol around children.
- When undertaking any assessment, cannabis use by a parent/carer is taken into account.

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