Serious Case Review
6 Step Briefing
Child Ak

The Background

Child Ak died shortly after his second birthday in 2017 due to a cardiac arrest having sustained a significant non-accidental injury.

Safeguarding Concerns

Child Ak had unsupervised contact with his father who was known to be a risky adult. There were concerns regarding mother's childhood experiences and how this may have impacted upon her ability to parent her own children, whilst remaining a child in her own right.

The Incident

Child Ak was in the care of his father at the time of the incident. Following a 999 call, an ambulance crew conveyed him to hospital where he sadly died. Child Ak was found to have high levels of various drugs in his body and multiple unexplained injuries and bruises.

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 Ak's life and the circumstances of his life and death.

The Findings

- A Strategy meeting (approximately three months prior to Child Ak's death) recommended a single assessment. The single assessment did not take place prior to Child Ak's death. It is hoped but not known if this assessment would have considered mother's history and the potential impact this may have had on her parenting capacity and addressed mother's understanding of the potential risk to her son by his father.
- Child Ak's voice was not heard and his day-to-day life experiences were not known.
- The level of formal involvement by practitioners and services in Child Ak's life had been stepped down or decreased in the months preceding the last three months of his life.
- Father was well known to the police and a specific police incident led to a Strategy discussion, however, it would appear that professionals did not fully appreciate the significance of father's chronic history of domestic abuse and extensive history of drug related offences.
- Working with interconnected families and the importance of understanding and mapping complex family networks is highlighted by this review as many people across the families that Child Ak was considered to be part of at different times were actively involved with statutory services.
- Child Ak and his maternal family were discussed a multi-disciplinary safeguarding meetings at the GP practice. It is not clear what information was shared from these meetings or whether the families are aware of them.

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The Findings

- When police officers attend an incident of domestic abuse, it is important to consider the child's voice. Although Child Ak was too young to express an opinion, officers could have imagined what life was like for him.
- There needs to be a better understanding and application of thresholds across frontline teams within the MASH.
- The recommendation for a single assessment in hindsight and on reflection should have been to proceed to a single S47 and Initial Child Protection Conference.
- There does not seem to have been an effective process for management oversight or a process to review the decision of the Strategy discussion.
- Assessments need to be child focused and include a 'Think Family' approach.
- Professional curiosity needs to be developed as an organisational culture.
- Young people who are also parents must still be considered under their own right by services.

Recommendations

Recommendation 1:

- Each agency is required to review guidance, procedures and training for practitioners and managers and ensure that: a) the fundamental message to 'think child or young person' is understood; b) any duty and expectation is fulfilled that a child/young person will be seen and that her/his views, wishes and feelings will be ascertained, taken into account and given due regard; c) the expectation is met that *anyone* who may contribute to an understanding of the child or young person's experience is heard and their views (and especially any reports of concerns) are recorded and shared with other practitioners as necessary and taken into account in assessments and responses;
- The Local Safeguarding Partnership requires evidence from each agency that they are meeting this recommendation and that the effectiveness of direct work with children and young people and the ability to understand the experience of a child/young person (informed by all available sources of information) is measured as part of key performance indicators.

Recommendation 2:

- That the Local Safeguarding Partnership and relevant partner agencies develop or review existing guidance and procedures for effective work with *young people who are parents* where safeguarding or the provision of services is required for both a young parent and her/his child - including the need for separate plans and appropriately differentiated services, resources and allocation of practitioners.
- That the guidance and procedures also consider the need for the careful assessment of the protective and parenting capacity of *the parents of young parents* especially where there are, or have been, concerns relating to the young parent's own experience in their care; where a household is shared; where *the parents of young parents* may be considered part of the caring, support or protective arrangements for a baby/child and her/his young parent.

Recommendation 3:

- That practitioners working with a parent who may have experienced abuse (especially including domestic abuse and/or exploitation) analyse and take into account the potential impact of those experiences on a parent's own understanding of risk and any assessment of her or his protective capacity.

Recommendation 4:

- That where there is statutory involvement, all practitioners are expected and required:
- To establish and update information (sharing with other practitioners and agencies where appropriate) about a child's or young person's parents and carers, wider family/families' members, associates and people of significance to the child (using genograms and ecomaps in all cases) - especially in relation to anyone who has parental responsibility and/or who is playing a part in caring for the child (formal, informal, regular,

Recommendations

Recommendation 4 continued:

- To establish information relating to the level of care or contact that a parent or carer has with a child (including any restrictions on, or conditions regarding, care or contact with any *other* children of that parent/carer);
- To include fathers or partners (including those who have contact) actively in all processes (especially in parenting assessments, meetings and plans).
- That the Local Safeguarding Partnership and partner agencies identify and promote approaches and resources relating to engagement and effective work with fathers or partners of parents.

Recommendation 5:

- That the Local Safeguarding Partnership and all partner agencies actively develop strategies, procedures, guidance and systems (including in relation to information management and recording) to enhance practitioners' and agencies' capacity to work effectively where there may be:
- Complex parenting arrangements, for example involving different parents – especially fathers/father figures - for several children within a single household;
- Parents, perhaps especially fathers, who have several children but where the children live primarily in several different households – but where there may be unsupervised, supervised or even staying contact;
- Several connected individuals or families (including those who may share a household) involved with statutory services and known to many different practitioners and services and who may have different allocated lead practitioners.

Recommendation 6:

- That practitioners, supervisors and managers are guided and required through advice, procedures, practice supervision and related training to:
- Maintain a clear focus on the impact on the child/young person (measured in terms of health, development and wellbeing) of parents' or carers' willingness and capacity to engage – both in assessments and in plans for work;
- To 'Recognise that noncompliance may be a parent's choice, but that does not mean it is the child's choice.' (*Pathways to harm, pathways to protection 2016 p.143)*;
- To be aware that 'Where child welfare concerns are identified, poor engagement by families should heighten concern and should not prompt case closure unless there has been a thorough risk appraisal.' *(p.147)*;
- To follow established single and multi-agency safeguarding arrangements and procedures to address any harm risk of harm where required and escalate continuing concerns – including where services cannot be provided.
- This recommendation links to learning identified in another current SCR (Ref 070).

Recommendation 7:

- The Local Safeguarding Partnership completes the current work to review and revise the multi-agency *Thresholds and Pathways* guidance (referred to as 'local protocols for assessment' in *Working Together 2018)* for work with children, young people and families at all levels – including, especially, at the locally-defined 'non-targeted early help level' and in relation to the role of the lead practitioner and related co-ordination of a single, shared assessment; a co-ordinated plan; and the promotion of child/young person and family engagement;
- The Local Safeguarding Partnership updates guidance to reflect any *future* changes in operational arrangements and related processes – at the time that any changes are made;
- That *partner agencies* similarly revise and update their own related agency-/service-specific guidance – at the time that any changes are made;
- That promotion and compliance with the guidance is evidenced through training and supervision;
- That the application of the guidance and its impact is monitored, especially in relation to: the appropriateness and quality of referrals; decisions relating to section 47 enquiries made at Strategy Discussion meetings; the start and completion of assessments (including within statutory required timescales and in relation to the principles and parameters of effective and 'high-quality' assessments as set out in *Working Together 2018*); on plans, pathways and outcomes of service provision - so that children, young people and families receive the right help at the right time.

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Recommendations

Recommendation 8:

- That where there is a concern that a child may have been in a situation where drugs were accessible to them, there must be a comprehensive risk assessment which will consider information or evidence of the accessibility of drugs within the household, and supervision of the child. A paediatric assessment should always be considered as part of an initial response or as part of all further enquiries or assessments.

Recommendation 9:

- That the Local Safeguarding Partnership requires assurance from Children's Services about the arrangements for managers', supervisors' and practice leaders' training and support in the First Response (or equivalent) teams; and
- In relation to arrangements for management and quality assurance within the MASH service.
- It is expected that this will be monitored through reports to the Local Safeguarding Partnership and, within the local authority, as part of the Improvement Plan.

Recommendation 10:

- That the Local Safeguarding Partnership review the all-agency guidance on information sharing to ensure that it is compliant with GDPR requirements, and promotes the principles for sharing information in safeguarding work set out in *Working Together 2018* (especially the guide on p.20);
- Evidence awareness of, and compliance with, the guidance across teams and services, in supervision and in training;
- Ensure that minutes from multi-agency meetings are shared with all relevant partner agencies, especially MASH Strategy Discussion minutes with health agencies and the police;
- Monitor instances when information sharing and management may have hindered or, equally, assisted effective responses to children and families.
- That all partner agencies review their own related guidance on sharing information both internally and with other agencies.

Recommendation 11:

- That the Local Safeguarding Partnership will monitor and evaluate the impact of strategic, operational, organisational and practice developments – including multi-agency arrangements and those of key safeguarding partners (particularly the local authority) - through a clear, open and transparent audit process identifying key indicators and relevant qualitative information and data to assist in the assurance of safe practice; and
- Champion appropriate resource allocation.

Recommendation 12:

- That the Local Safeguarding Partnership (through the Quality Assurance Sub Group or equivalent, as appropriate) monitors and tracks the implementation and impact of all the specific agency recommendations from the IMR (Individual Management Review) reports and related action plans, as well as the recommendations and action plan relating to this overview report.

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