Briefing on Serious Case Reviews

Child H (Published by Lambeth LSCB, 2014)

Background

Death of a 3-year-old Somalian boy, Child H, and serious injury to his 2-month-old brother, in March 2013. Father has been charged with Child H's murder and his surviving siblings have been taken into care. Family had previously been separated by civil war in Somalia and spoke minimal English. Significant history of domestic abuse including an incident leading to mother spending three months in a women's refuge. Issues identified include: insufficient attention paid to past incidents of domestic abuse; professional focus on the emotional impact on children of living with domestic abuse, not on the increased risk of physical harm; lack of reassessment of the family's situation despite indicators of increased risk of harm including overcrowding and new and stressful family relationships; and inadequate range, availability and quality of interpreters. Uses the Social Care Institute for Excellence (SCIE) systems model to pose questions to Lambeth Safeguarding Children Board.

Key Learning Points:

Impact of Domestic Violence & Abuse

- In this case there was a tendency among professionals in all agencies to focus on the emotional impact on children of living with domestic violence, and not on the increased probability that they will be physically harmed. This can impede a full understanding of the risks to which they are exposed. Risk assessment tools should look at the risks to the children of direct physical abuse.

- Child Protection Conference Chairs should review the categorisation of children on Child Protection Plans and stress the correlation between Domestic Violence and physical abuse in the conference and risk assessment.

- Following this review, Lambeth aspires to move towards the full-scale implementation of the Signs of Safety model to strengthen the quality of risk assessment, make concerns more easily understood by parents, and frame Child Protection Plans in a way that is more outcome-focussed. This was in recognition that where there is no known recurrence of domestic violence incidents, professionals may feel reassured about the welfare of children in the household and/or believe their grounds for purposeful engagement with the parents are diminished. The consequence is that they get no further in understanding the causes and triggers of incidents of domestic violence, and the actual level of risk to children these imply.

Use of interpreters

- This case highlighted that the range, availability and quality of interpreters was problematic; for planned work it was variable and, in emergency situations, it was so poor that it risked leaving non-English language service users without support, making it extremely difficult for professionals to make an effective assessment or diagnosis in a timely fashion.

Learning for A&E

The following changes were implemented in Lambeth for acute services following this SCR. These include:

- Risk assessment tool introduced to A&E for use when NAI is one possible explanation for the presenting complaint

- Lead consultant for child safeguarding, particularly for the more medical aspects, e.g., interpretation of injury, for each specialty identified.

- Lead consultant identified and notified on admission whenever child safeguarding concerns are raised.

- Ward team assess risks in respect of the child's safety on the ward when NAI is a possibility and implement appropriate measures, e.g., positioning child close to nursing station, restricting visitors.

Differential diagnoses

- A pursuit among social care and police staff of categorical explanations from medical professionals of the cause of physical injury to children, clashes with a norm among medical professionals of giving differential diagnoses in which anything is possible until it is ruled out. This can increase the chances of miscommunication and misunderstanding about past and future risks in child protection investigations.

- Social work teams should record on the day the key findings and actions arising from a Strategy Meeting, and give those to the attendees on the day. This should be audited for assurance.