Briefing on Serious Case Reviews

Child I (published by Lambeth LSCB 2015)

Death by drowning of a 20-month-old boy in July 2013. Child I was found face down in the bath; mother reported she had left Child I in the bath, informing father she had done so, before leaving the house. Child I and his two older siblings were subject to child protection plans under the category of neglect at the time of the incident. Parents both had learning difficulties and at times reacted with anger and hostility to professional interventions. The family were receiving support from a wide variety of services, including: health visiting, children's centres, home start, enhanced midwifery support, community outreach, a health early intervention worker and enhanced support from a school. Key issues: lack of intra-agency ownership and accountability for front-line practice; professional emphasis on investigating some physical injuries, at the expense of considering indicators of neglect; hostile parental behaviour distracting professionals from protecting the child; and overreliance on written agreements with parents to support child protection arrangements. Uses the Social Care Institute for Excellence (SCIE) Learning Together model to set out key findings and pose questions to the Lambeth Safeguarding Children Board.

Key Learning points:

- There is an insufficient understanding of the concept of neglect and how to recognise and understand the cumulative impact of this on the health and development of individual children. This results in children continuing to experience neglect despite input from professionals across all agencies. In the case of Child I, professionals placed significant emphasis on investigating and 'proving' some physical injuries, at the expense of considering numerous other indicators of neglect. Neglect cases were not sufficiently prioritised for discussion in supervision

- The lack of multi-agency ownership of how children are safeguarded means there is insufficient professional challenge and debate, compromising the quality of safeguarding work. This case suggests that the Local Authority is seen as owning the responsibility to protect children rather than it being a shared responsibility. There was insufficient scrutiny of children who had been subject of Child Protection Plans for over 18 months. One non-social work professional in the case group stated that '*if a child is the subject of a child protection plan, we all (*other agencies*) will stand back and breathe a sigh of relief*'

- The confused professional response to families where parents have a learning difficulty has a detrimental impact on safeguarding work. No referral was made to the Adult Learning Disability Service despite professionals believing that both parents had learning disabilities. There was a lack of informed response to their needs and professional energy was at time focused on them, which diverted attention from the children.

- Father had been in care. There was inadequate involvement of the father in assessments and intervention plans.

- There is a lack of rigour in ensuring child protection conferences and core group meetings are functioning effectively. Child protection procedures regarding pre-birth work were not followed in this case and the issues regarding the new baby were not considered separately

to the other siblings already on plans. Membership of the core group did not include all appropriate multi-agency staff so first-hand information was not available. There was a lack of clarity about the role of the core group.

- When children are already on a child protection plan, there is a tendency for additional concerns not to be investigated through the correct child protection process. The assumption is that this will be addressed at the next child protection conference or core group. In this case, there were a number of incidents and bruising that should have triggered s47 investigations.

- Working with hostile and aggressive parents needs to be more effectively managed to prevent losing focus on the children In the case of Child I, professionals avoided challenging the parents and this compromised work with the children. Professionals did not understand the underlying reasons for parental hostility and were unaware of the existence of procedures to deal with this.

- The questionable use of written agreements to support the child protection process. In the case of Child I, these were ineffective, with breaches not dealt with, and it is unclear how much the parents understood (neither parent could read). There is considerable evidence of the risks of written agreements providing a false sense of assurance to professionals.